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International Development Committee

HIV/AIDS: Marginalised groups and emerging epidemics

Second Report of Session 2006–07

Volume II

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Oral and written evidence

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International Development Committee

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Witnesses

Thursday 16 November 2006

Written evidence

Written evidence submitted by witnesses who also gave oral evidence:

Other written evidence:

Witnesses

Thursday 16 November 2006

Dr Anindya Chatterjee, Senior Adviser, Prevention and Public Policy, UNAIDS,
Kim Mulji, Executive Director for External Affairs, Naz Foundation International and
Joseph O'Reilly, Senior Policy Adviser on Preventing International HIV/AIDS, Alliance

Written evidence

Written evidence submitted by witnesses who also gave oral evidence:

1 Department for International Development
2 International HIV/AIDS Alliance
3 Naz Foundation International

Other written evidence:

4 African HIV Policy Network
5 HelpAge International and Help the Aged
6 International Planned Parenthood Federation
7 Naz Project London
8 Plan UK
9 Results UK
10 SABMiller
11 World Vision

Oral evidence

Taken before the International Development Committee

on Thursday 16 November 2006

Members present:

Malcolm Bruce, in the Chair

Richard Burden
Mr Quentin Davies
James Duddridge
Joan Ruddock

Witnesses: **Dr Anindya Chatterjee,** Senior Adviser, Prevention and Public Policy, UNAIDS, **Mr Kim Mulji,** Executive Director for External Affairs, Naz Foundation International, and **Mr Joseph O'Reilly,** Senior Policy Adviser on Prevention, International HIV/AIDS Alliance, gave evidence.

Q1 Chairman: Good afternoon and thank you very much. May I first of all apologise for the delay in starting the meeting. It does not in any way reflect the importance of the issue, not least because we took a decision last year that we wanted to have an annual update on progress to achieving the international targets on AIDS reduction and elimination. The fact is that this meeting has had to be rearranged twice because of ministerial engagements and unfortunately the week of the Queen's Speech is always a difficult week for Members' diaries, but there are one or two colleagues, I hope, who will join us as we proceed. Perhaps you could briefly introduce yourselves for the record.

Mr Mulji: Good afternoon. My name is Kim Mulji and I am the Executive Director at a small NGO called the Naz Foundation International. We focus on addressing male-to-male sex and HIV and AIDS issues, mainly working in south Asia, but also looking elsewhere in developing regions.

Dr Chatterjee: Good afternoon. I am Anindya Chatterjee and I work as the Senior Adviser on Prevention and Public Policy for UNAIDS, the joint United Nations programme on HIV/AIDS.

Mr O'Reilly: I am Joseph O'Reilly, the Senior Policy Adviser for the International HIV/AIDS Alliance.

Q2 Chairman: Thank you very much. As I said at the beginning, we attach enormous importance to achieving the international objectives on AIDS, not least because aid and development and the achievement of all of the other Millennium Development Goals (MDGs) could be destroyed by a failure to grapple with the AIDS epidemic and I think that is generally recognised. Although we have set ambitious targets, we are already failing to meet them and we have missed the "three-by-five" and, although progress has been made, it would appear that we are not very close to achieving what we have set out to do. Perhaps I could ask you briefly as a starting point what, in your assessment from where you are on the basis of the progress which has and has not been made, do you think realistically are the prospects of achieving the universal access to treatment by 2010, and the reversal of the spread of the epidemic by 2015 as things stand at the moment?

Mr Mulji: My expertise comes from addressing male-to-male sex and HIV and AIDS. I think we are going to be a long way from reaching this target certainly by 2010, certainly in South Asia, which I know, and also, I think, elsewhere in Asia and maybe in other areas, like sub-Saharan Africa and North Africa for a number of reasons. The first reason is that it has not really been addressed in many of the countries' national AIDS plans and where it has been addressed, it has either been addressed poorly or it has been addressed, but without necessarily the power to implement those services that are required. For example, in India where they have just developed a new strategic AIDS plan, it does not include the issue of male-to-male sex, so, for example, developing 350 projects across the whole of India to specifically address prevention work around male-to-male sex, 350 small community-based projects, which is, in our opinion, the right way to do this, but it is without necessarily the power to enforce it. For example, in India there is a federal structure where the local states decide their policy, so we are not entirely sure how the policy at one level is correct, but how that will transpire into projects on the ground. In other regions, such as China, they are just starting to recognise male-to-male sex as an issue, but elsewhere it is more tricky. In Bangladesh, for example, a recent proposal for the global AIDS fund, the Global Fund to fight AIDS, TB and Malaria, said that they were happy that there was enough coverage on male-to-male sex and HIV prevention work which clearly does not ring true in terms of what we know is happening on the ground from people we know who are working there. Elsewhere, in sub-Saharan Africa, for example, countries just refuse to acknowledge that there is male-to-male sex, so we do not really know what is going on. Elsewhere in the region, for example, in Latin America and the Caribbean, there is a lot of misrepresentation of what is going on and it is represented as not really a male-to-male sex epidemic and it talks about the regendering of AIDS which is fine, but it tends to leave out crucial vulnerable groups which is still in many respects the core where the epidemic is happening. Just as a final bit of information on this, I have just recently been in Egypt and talking to UNAIDS there, where, from

what we know, the HIV prevalence level is very low, but a recent study, unpublished, I have to say, by an NGO there will show, I am sure when it is published, that HIV prevalence levels have been about 5% to 6% amongst males having sex with males there, so there is actually a problem in Egypt amongst males having sex with males, but the Government of Egypt does not recognise it and no one else is really recognising it. There are hidden epidemics which really need some political commitment and also the power to make sure that these projects happen on the ground, so I think there is a lack of political leadership and recognition, there is a lack of a means to do that and also I am not entirely sure that bilateral funders, such as DFID and other people, have created the mechanisms to enable us to ensure that there is universal access to prevention, treatment and care.

Q3 Chairman: Perhaps I could insert a supplementary question for you to consider and that is, reading the DFID memorandum[1] to the Committee and the general international statements, they are quite strong on funding as a standard political commitment to inputs, "We'll deliver this amount of money", but not so good on outcomes, so the money is going in, but the question, I suppose, which has to be taken as a supplementary is, is it being wasted or spent on the wrong things or is it addressing the right issues, just perhaps as an additional point to comment on?

Dr Chatterjee: If we look at the way the programmes have been scaled up globally, both prevention and treatment, compared to 2003 and 2005, there has been quite a bit of an increase in volume of programming globally. However, having said that, it is nowhere near a level which would halt or reverse the epidemic and, as we stand here today, another serious problem is that the programmes are failing to reach those who are at the highest risk and those who are most vulnerable. This is a fact and, therefore, the political process in the High Level meeting this year and the national target-setting exercises that are taking place as we talk here today, provide us with opportunities to dramatically scale up both prevention and treatment. Whether we make it or not, I do not want to be commenting on that, but there is no other alternative than to try all means to dramatically scale up. The alternative is not there.

Q4 Chairman: So it is money as well?

Dr Chatterjee: It is money as well.

Mr O'Reilly: First of all, I think it is very important to say that the commitment to universal access, which the British Government played a very important part in our securing and which this Parliament really prompted them to do, is extremely important and it is one that we all welcome. However, the meetings at which that universal access commitment was secured, such as the High Level meeting earlier this year at the UN in New York, I think provided us with a stark indication of the struggle that we are going to have in realising the promise of universal access for members from marginalised communities, the subject of this inquiry. I and many of my colleagues, who are behind me today, were at that meeting and were enormously frustrated at the failure of the international community at that meeting to even acknowledge, let alone do anything about, recognising the special needs of those key populations and for a time during the course of those negotiations they were stymied by a failure to come to any agreement about even referencing in the text gay and other men who have sex with men, injecting drug-users and their special needs and, as a result, the document is completely silent on them, so I think it gives you an indication of how far we have to go from making the rhetoric about universal access true on the ground. In addition to that of course, there are other real problems. The populations that we are talking about, drug-users, commercial sex-workers and men who have sex with men, face enormous amounts of official hostility in many developing countries. They are silenced and made invisible. This has enormous implications for programming, so one of the first things is that in terms of research and knowing what we have to deal with, there is not only indifference, but an absolute failure to undertake research which seeks to understand how many men, sex-workers or injecting drug-users there are, what their patterns of risk behaviour are and what could be done to address them, so there is a gap in the political will and there is a gap in the knowledge that we have. I just want to close this answer by saying that there is a huge services gap as well. Despite the fact that outside of sub-Saharan Africa, injecting drug-use constitutes one third of new HIV infections, only 5% of injecting drug-users around the world have access to the most basic forms of prevention services, clean needles, information and peer support, to help them to change their risk behaviour. For men who have sex with men, less than one in 10 men who have sex with men have access to the basics, such as condoms and lubricants. It is slightly better for commercial sex-workers, but about 85% of them do not have access to any of those services, so there are huge gaps. The promise of universal access is an important one and it is one that we have to work to, but I think a real question for us is what will constitute universal access. Universal access for the general population will be extremely important and valuable, but in most countries there is a huge gap to be overcome in securing access to the most basic services for the populations which this Committee is concerned with.

Chairman: I think in the background evidence that we have had, those points have been quite strongly made. The point that has been made basically is that these marginalised groups are not only marginalised in terms of their rights, but very often they are the drivers of the epidemic, so if you only concentrate on the mainstream, you are not going to turn the problem around. When the Committee was in Botswana, for example, we asked the Health Ministry there what they were doing about male-to-male sex, what they were doing about the sex trade

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and sex traffic, which is very rife on the borders of Botswana, and the answer was, "They're illegal". That was the answer and that, I think, we will come back to because that is the whole problem, actually accepting that you can address that problem without necessarily condoning or legitimising it.

Q5 Richard Burden: The impact of the HIV pandemic on sub-Saharan Africa is pretty well known these days, but there is obviously some increasing evidence, and you mentioned it today, that it has been perhaps understated elsewhere, and you have mentioned Egypt, but Central Asia, the other parts of Asia and indeed parts of Eastern Europe are also showing some very worrying signs. Now, if we are going to ensure the universal access to both treatment and prevention in the way you say, what are the kind of policies that we need to be looking for? Obviously we need the research because without the research, you do not know how to do the targeting, but what are your views about the kind of implications there are in those countries and what we need to be doing about it?

Mr O'Reilly: When we talk about responding to HIV and particularly with respect to prevention, there is the Holy Trinity of interventions: there is risk reduction; vulnerability reduction; and impact mitigation. Our contention is that, by and large, we can see some work, albeit often not sufficiently comprehensive and evidence-informed, in respect to helping communities reduce their risk and there is some work around impact mitigation, particularly, for instance, the mobilisation around treatment which is extremely welcome and important, but the biggest failure, in our view, across those three areas is in vulnerability reduction. This of course relates to the Chairman's very point about the legal status of most of these groups, the fact that marginalisation, discrimination, stigma and invisibility fuel HIV infections for these groups which makes them much more vulnerable to HIV, their legal status, their inability to access services, their treatment by official service-providers, but not only that, which is a big issue, but once people are either infected with HIV or imputed to be so, HIV stigma and discrimination exacerbates the impact of HIV. Therefore, a whole range of human rights violations fuel and exacerbate the impact of the virus on these populations, so you kind of have a problem with the legal status and the rights and the ability to claim those rights for all of these populations. For instance, let me say this with respect to injecting drug-use, that in almost all of the countries in which we operate, injecting drug-use is illegal as is often commercial sex-work and homosexuality, and that means that people are often not able to come forward and access services for fear of imprisonment, arrest, torture, arbitrary detention, or when those services are provided, say, for instance, to injecting drug-users, so you might have needle and syringe exchange programmes often operating in the shadows of the law, if individuals are picked up with clean needles and syringes, then they are taken to police headquarters, and that is the same for all of these groups, so it is very difficult to create what the international AIDS Non-Governmental Organisations call "an enabling environment" in which these issues are addressed, so vulnerability reduction for us is crucially important. The other area too is that one of the biggest human rights violations which fuels the epidemic is the violation of the right to health because of that health services gap that I talked about. You cannot have a right to health and you certainly cannot exercise it without basic access to health services and for people who are vulnerable to, and heavily burdened by, HIV, those health services are essential to exercise their rights to health, so in fact their right to life is put in jeopardy by their inability to access health services. Therefore, a combination of this Holy Trinity of interventions, risk reduction, impact mitigation and vulnerability reduction is important, but, for us, we have seen probably not enough attention to any of these areas, but certainly insufficient attention paid by the international community in general and many developing country governments in particular to reducing the vulnerability of these groups and helping them to safeguard, and exercise, their rights.

Mr Mulji: Just to follow up what Joseph has been saying, I think that the top-level answer really is about political commitment, that we really do need to advocate for working appropriately with marginalised groups, with injecting drug-users, with female commercial sex-workers and males who have sex with males. We need to provide political leadership and the United Kingdom Government needs to work further on this in terms of kind of having a level where things should be done at, so in terms of addressing laws which make consensual adult behaviour between men illegal, for example, in India, supporting work around legal reform around the decriminalisation of drug-use and so on, so creating an enabling environment, as Joseph has said, on the legal issues, but also an enabling environment on human rights issues, so addressing stigma and discrimination. It is not only finances, Chairman, as you said. There are the finances available, but it depends on that political leadership for wanting to call down those funds as well to address work on marginalised communities, so I think it really very strongly is about political leadership and certainly a role for the UK Government could be continuing this. It is very, very good, I think, about providing that leadership, but it is about continuing on that track to do that work so that countries do address the marginalised communities and behaviours.

Q6 Richard Burden: Could you give perhaps some examples of the kind of things you would be looking for. If, say, a Minister from the UK, or indeed from elsewhere, said, "Ok, you're right and we're prepared to provide that political leadership to address that Holy Trinity of issues. I want to get the political profile of this up, but how do I do it? What do I actually need to do? What are the things I actually need to be arguing for? What can the international community do on that", do you have any ideas?

Dr Chatterjee: In all of the emerging epidemics, a key disconnect is between the ministry of health, the national AIDS programme or the national AIDS council; and the ministry of the interior, the ministry of home, the drug control organisations and the criminal justice system. Therefore, a key issue for political advocacy is to speak with one voice, to bring multiple ministries' perspectives together and that will make programming possible in a much bigger way. For example, in China for a long time, despite a very serious epidemic in the southern part among injecting drug-users and subsequent spread all over the country and a rising sexual transmission, it was very difficult there to start up clean needles programmes or methadone treatment until the Public Security came on board. And here is an example where the Public Health and Public Security could come together and could agree on a common agenda of intervention. The international community played a big role, the UK Government's programme in China played a big role. The policy statement that was issued by the UK Government on harm minimisation brings together different ministries of the UK and it gives a clear indication that all the government entities and departments are together and have a common view. We try to do the same thing in the UN. I think we all have to work together in bringing these perspectives together for two reasons, the first being, as Joseph said, that we have to systematically address all legal barriers and subsequently social barriers that are stopping us from scaling up and, secondly, it is at the end of the day political leadership that brings everyone under one forum and not the law enforcement perspective clashing with the public health perspective, thereby making programming really difficult.

Mr O'Reilly: If I might answer Mr Burden's question as well, it is a crucially important one. One of the things I would say too is that the UK Government has done a lot and one of the initiatives that they took last year as President of the EU and G8 was on World AIDS Day to issue a statement on the UK Government's approach to harm reduction. I think in our written evidence[2] we point to the fact that that is one of the areas where there is an inconsistent approach among the international donor community to this issue. The United States, for instance, opposes the use of any of its funding for harm reduction activities and, in particular, the provision of clean needles and syringes. In terms of international policy-making, in our view, the UK Government's statement last year, which was very clear in respect of their position, was extremely important, as, I might add, was the Secretary of State for International Development's speech to the UN General Assembly at the High Level meeting on AIDS where he took on international opposition, including that of the United States Government, to condom promotion and to the promotion of safe sex to general populations, so it is extremely important and those things have already played an important role, but our view is that the British Government could do more, and I want to give you a couple of very specific examples quickly. One is that we could do more and better by having a more coherent approach to these issues across government departments. I think there could be a lot more consistency and coherence between the Foreign and Commonwealth Office (FCO) and the Department for International Development. The FCO has a range of initiatives, the Human Rights Challenge Fund, and its global diplomacy initiatives which could integrate HIV much more readily and around which some of the themes which they take up could address HIV issues and I think a joint strategy on both of their parts would be extremely important. The other thing is that we can look at other government departments' initiatives in these areas for some inspiration. Earlier this year the Secretary of State for the Foreign and Commonwealth Office appointed an international ambassador, a special representative for climate change, and that individual is using his good offices on behalf of the British Government to create a focal point internationally for action on this issue. One of the things which we have written about and you have heard about already today is the lack of consensus at the international level amongst the international community around the rights of sexual minorities. Now, that should not come as a surprise to us, but one of the things that the British Government has done, and done well, is promote the rights of sexual minorities in this country, so we have the capacity in a sense to go to the international community in a way with that background. We have a good approach to the rights of gay and lesbian people in this country, to anti-discrimination legislation and to dealing with the HIV epidemic *vis-à-vis* them, and we are calling on the Government, and we would encourage the Committee to consider recommending this, and for the Department for International Development to appoint a special representative, in exactly the same way as the Foreign and Commonwealth Office has on the question of climate change, for sexual minorities. The international community at the UN is not at a point of agreement around an international declaration, for instance, or a new convention on the rights of sexual minorities, but what I think the good offices of the British Government could do is work with countries on a bilateral basis to generate greater community interest and political will aimed at securing greater recognition of the special needs of sexual minorities in the international community and the UN in particular. The final thing I would say in respect to HIV and human rights is that the United Nations' AIDS programme is the focal point for human rights and HIV issues internationally, but that remains massively under-resourced and unsatisfactorily addressed, in our view. The international community, led by UNAIDS, needs a human rights and HIV action plan and it needs a special representative on HIV and human rights so that that person can create a focal point for exploring the relationship between those issues. The Special Representative of the United Nations on the Right to Health, Paul Hunter, a British citizen, supports this initiative on our part because his

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mandate, in his view, is not sufficiently broad to incorporate those issues and address them, so we believe that, by this very simple, in a way, series of initiatives, a great deal more focus could be brought to bear on these issues and the British Government could play an important part in providing the political leadership which would make a real difference to them.

Q7 Chairman: That is helpful, but partly in response to Mr Burden's question, perhaps could you also address the regional variations and what is being learned or failing to be learned. For example, I mentioned Botswana earlier and we actually, when we visited Botswana, were looking at a programme there. There is an opt-out rule where if you don't opt out, you automatically get tested and, as a result of that, they have identified many of the AIDS sufferers and been able to give them treatment. Is that something which could be replicated elsewhere and are there other good practices or bad practices that could be highlighted and would even be relevant to whatever a special envoy might usefully do internationally?

Mr Mulji: I want to talk briefly about three things. In terms of good practice, the UK Government has been actively, and closely, working with the Government of India in preparing their third national AIDS plan and they have included marginalised groups and marginalised behaviours very clearly in that plan. It is a very good strategy, talking to our colleagues on the ground, so that has been a very, very good thing which the UK Government has done. I want to touch on three things though, which is the UK Government's support to changing the legal, policy and social environment in countries. I think specifically in bilateral discussions with countries, such as India, we should address their failure to decriminalise consensual adult homosexual behaviour and the specific barriers to working with communities. I think we do need to specifically go to these countries and say that they need to change the laws and create enabling environments. On funding, the UK Government will provide bilateral funding, for example, to India to implement their strategy which we have helped to develop. I am very concerned though that we will just give the money to the Indian Government and they will spend it on their particular priorities and it will not necessarily get spent on what the UK Government think are their priorities. I think there should be some accountability because if we give money to the Indian Government, we should know where that money is going and it should follow some of the priority areas.

Q8 Chairman: That is a bit of a problem when we believe in country ownership of programmes.

Mr Mulji: But if we are helping them to develop the strategy, we should hold them accountable, I think, and it is UK taxpayers' money, so we should get them to spend it on things which we think are appropriate and are priorities. Also with multilateral funds, we give money to the EU and it funds HIV and AIDS work in developing countries which is to ensure that their policies and where they spend the money are correct and funds, such as the Global Fund to fight TB, AIDS and Malaria, we should ensure that where they spend their funds and their priorities are coherent with the UK Government's policies. Thirdly, I think the UK Government should also take a strategic approach on how it funds and supports work specifically on marginalised communities, so whether that is work on male-to-male sex or work with drug-users, we need to have a strategic approach. For example, the UK Government and DFID, through their office in India, are funding the scaling up in four states around male-to-male sex and we have been implementing this programme for the last number of months and it has been very successful, but the UK Government cannot hope to scale up bilaterally all the work that we need to do even just in India, so I think we need to be more strategic and to fund organisations and to fund programmes which will help pull in those funds. There are funds, for example, through the Global Fund to fight AIDS, TB and Malaria, but I think the UK Government could be a much more strategic player in addressing marginalised groups and behaviours.

Dr Chatterjee: We are dealing with extremely diverse epidemics and even within countries there are many epidemics at the same time and we really need to invest in understanding what drives these epidemics. So we are moving from understanding rates and prevalence to drivers more and more. Secondly, we are also dealing with changing situations. We see the emergence, and the rapid explosion, of HIV among men who have sex with men in many Asian countries, we are seeing injecting drug-use in sub-Saharan Africa, and epidemics are maturing and changing and we really need to be on top of that. I think we have two sets of problems, if I may classify. One is the problem of coverage, that we are not reaching enough people and there are many barriers which we have talked about, human rights being one of them or the neglect of human rights being one of them. The second set of issues is whether our money is going where it is needed and tracking the resources, the deployment of resources on the ground. If we have a better system, we will definitely be able to improve on our performance. I am giving a simple example, that in tracking AIDS funding, the national AIDS accounts in Latin America showed that whilst male-to-male sex is a major driver of the epidemic in that region, very few resources are being deployed in that area. There are countries for example in western Africa where you would see that 95% of infections are in the context of paid sex, whereas only 5% of the national AIDS budget is being deployed for that, so that is a serious problem. And along with understanding the drivers, we do need to track the resources at the ground level, not only at the international level, which we can do much better than before. We have to invest in finding out where the money is deployed, whether it is the best use of the money and whether we are being able to address the drivers of the epidemic as it is unfolding, changing and emerging.

Mr O'Reilly: Perhaps I can follow up very briefly on that?

Chairman: Just briefly.

Mr O'Reilly: One of the things that we have suggested in our written evidence is that the UK Government can lead the way in some of that, because knowing where the money is going and how you are spending it is very important at a country level, but for international donors they can provide, I think, a very useful role model in doing exactly the same. One of the things that we have said is that we welcome the Government's commitment to the whole populations in *Taking Action*, the Department's strategy on HIV/AIDS and its reference to those things, but I think it is a failure to detail what it is going to do, and certainly a failure to tell us where the money is going. The Department's evidence before the inquiry was very illustrative for us of that problem. It was great to see all of the examples but if it were not for the inquiry asking, it would not be easy for us to find out that information because there is no tracking of that data and that effort. Effort is no doubt there, so it is something that we should take credit for and use to leverage internationally other people's support for similar work, and we would like to see better and more transparent data on those questions from the British Government.

Chairman: As you will appreciate, the Minister is going to be here immediately after you, so we will have a chance to address that.

Q9 James Duddridge: Both in the evidence received before and the evidence heard today everything keeps coming back to the key populations—the sex workers, male-to-male sex, prisoners and injectors, which is enormously sensitive politically within countries and also religiously for people who hold moral views about people who practise those types of behaviour. Are these the main factors that deter policy-makers from really engaging in these situations, and as policy-makers or people holding policy-makers to account how do we overcome these deterrent factors?

Mr Mulji: It is partly about providing evidence about what is really going on on the ground. I remember at a previous conference on AIDS an Indian doctor standing up and denying that there was any issue to do with male-to-male sex in India, so having some facts to present to people, some clear, cold facts, is helpful, but it is partly about getting an evidence base as well. There is creating an evidence base and also creating a coherent picture and doing the research so that we know what is driving an epidemic within communities and outside those communities, so that we have a clear picture. What is very much lacking in the data is that we really do not know the prevalence of male-to-male sex in lots of the regions in the world. We have very little accurate data on HIV prevalence, the HIV incidence between men having sex, so we lack a very good data set, so, of course, it is very easy for people to say, "There is not a problem here really", because some of these issues, as has been mentioned before here, have been hidden and swept under the carpet. They are issues that people do not want to talk about—commercial sex work, injecting drug use, male-to-male sex, issues which are socially stigmatised and discriminated against, so it is much easier for people to ignore them. The reason we do not have the evidence is that they are so discriminated against and stigmatised, so it is part and parcel of it and we have to have break up the vicious cycle and open it up. I always think that HIV falls into the cracks in society, the cracks that we do not like to look into because they are homosexual sex, drug use, paid sex work. We need to shine a light onto those cracks, see what is going on and present the evidence with an argued case.

Q10 James Duddridge: Does opt-out testing help in that? Do you have any evidence, for example in Botswana, that if somebody thinks they have got AIDS and they might feel they have got ill, they might generally, say, access the health system and they automatically get tested, so that is one way of bringing them in? Is there evidence that that works in Botswana, and if that is the case is it something that could be used elsewhere?

Dr Chatterjee: Despite having reasonable access to health services and anti-retroviral treatment, a major barrier which stops people from seeking treatment is stigma and discrimination. It is very obvious in many countries in sub-Saharan Africa. Botswana has had much more access than the neighbouring countries in terms of access to health services and anti-retroviral treatment. The way testing is organised in Botswana definitely has led to more uptake in the last couple of years, and Botswana is one of the countries which has, by its 'three-by-five', targets, been able to put many people into treatment. In the first round of experience and audit the success has been to enrol more people into treatment because of the way HIV testing was organised, that you have to say no; otherwise you will be tested. Having said that, we have to be very careful advocating that approach for every country because situations vary enormously and stigma and discrimination are rife. In many settings there is no confidentiality in the healthcare sector. And therefore, whichever way testing is organised, "Confidentiality, Consent, and Counselling" can never be ignored. And the Botswana approach holds promise in many high prevalence settings if these conditions are adhered to and maintained.

Mr O'Reilly: The question of routine or opt-out testing is one that is exercising the international AIDS community at the moment and it is quite a controversial one in some ways. The fact that it has a different role to play in different country epidemics is very important. In generalised epidemics one can understand the rationale for encouraging people to test. In epidemics that are more contained, and certainly in places where epidemics are concentrated among some of the key populations that we are talking about, encouraging members of key populations to test is a good idea if there are services in place that follow the results, if there is capacity to provide people with information about positive prevention and if there is also information and,

obviously, access to treatment. Those things are very important, but knowing your HIV status is not necessarily that important if you do not have access to things that allow the consequences of that to be delivered. The quick thing I would say in places where epidemics are more concentrated is that if the epidemic is associated with those populations and you test people then people are often imputed to be part of an illegal community or an illegal behaviour and so the stigma and human rights violations that follow from that association can compound and exacerbate and fuel infection, and so you want to be careful about routine or opt-out testing in places where it really is not fit for purpose and where the results of those sorts of things are not necessarily going to advance how you treat and deal with the impact of HIV.

Q11 James Duddridge: One of the reasons we are engaged on this problem is probably one of the wrong reasons in that the general population is being affected by the behaviour of a minority. It is good that the general population are getting involved in these minority issues but normally people on lower or middle incomes who are suffering from these health issues do not have advocates. What can DFID be doing to create a better advocacy of those groups generally rather than simply relying on that the general populace is scared of getting infected through heterosexual sex within their own country and an epidemic taking place elsewhere? What can be done from an advocacy perspective?

Mr Mulji: DFID can continue what it started already, for example, supporting the network we have created in India and elsewhere in South Asia and other areas in Asia, which is a network of organisations and individuals and groups working around male-to-male sex. It is very important and a powerful advocacy tool to have networks and organisations which come together. In addition to that, DFID have specifically funded a human rights network in India which we have been helping to set up. You were talking about coherence between the Foreign Office and DFID. Initially the Foreign Office supported a study that we undertook in India and Bangladesh around legal barriers to working around male-to-male sex and HIV, a very interesting study of which I can send a copy to the Committee if you would like[3], which shows some of the barriers around discrimination, lack of education and legal reasons why people do not access services. We have helped create standing committees at a national level in India and Bangladesh which will focus on human rights and male-to-male sex, and also local advocacy cells, so if the police start attacking people for cruising in a local park the local advocacy cell can help address that. If it is a more national issue they can also help deal with that, so it is supporting networks of organisations generally looking at HIV and AIDS, the networks within and without those, specifically focusing on different issues, be that drug users as well.

[3] NFI, *From the Front Line*, www.nfi.net

Mr O'Reilly: It is an extremely important area. The Alliance has been working, for instance in Cambodia with the assistance of the Bill and Melinda Gates Foundation since about 2001, with key populations—men who have sex with men, injecting drug users and commercial sex workers and, just by way of example, the approach that we have taken is to support the creation and development of capacity of community based organisations of those very groups at a very local level to provide peer support, to provide training, to distribute condoms, but also to identify their needs, to develop a shared understanding of their needs and to begin advocacy work. At a local level that can often be talking to the local police, encouraging them not to harass the sex workers of the local brothel, to take a more benevolent approach to men who have sex with men (MSM), and I have to say it works, but not only has it worked locally in that particular country. In 2001 our linking organisation in Cambodia, the Khmer HIV/AIDS NGO, went to the government and started talking about MSM and the government said, "There aren't any MSM in this country. They just don't exist". The creation of these support groups at a local level, then at a provincial level and then nationally in the form of a national network took place with the support of the Alliance over that period of time, and since then, through their efforts, through demonstrating that they exist, through demonstrating their needs, through making them visible, the government has not only recognised that men who have sex with men are key to the epidemic in Cambodia but they have also recognised that they are key to responding to it. They are part of the new Cambodian National AIDS Plan; they are enumerated in the plan as a key group. Only last year the government committed to including men who have sex with men in its sentinel surveillance, in its routine data collection on the extent of HIV prevalence in-country. Those are crucial, important things that have happened in that country by virtue of doing exactly what you suggest, which is supporting the creation of community organisations which can advocate for themselves, claim their rights and interact with government to try and influence and create more space around those very questions.

Q12 James Duddridge: Can I extend the question: is there also any contrary evidence that a more liberal attitude towards these activities and provision, for example, of condoms to target groups and needles for injecting could encourage greater use as well in some communities, or is it your belief that there has been no evidence whatsoever of that argument that you quite often hear, certainly from the religious right in America?

Dr Chatterjee: There is no evidence in any country that programmes have led to increased drug use or increase in sexual activity.

Q13 Chairman: There is genuine debate amongst activists, is there not, that by working with people you can perhaps engage in the moral issues without actually criminalising or marginalising them, that

actually you may have more success rather than less success? Mr Duddridge hits on an obvious sensitive button with the like of the President's Fund. All the practitioners on the ground say it does not work but puts quite a lot of money in. Bob Geldof is quoted as saying it sometimes gives women the right to say no. I do not know how effective that is but that was his assertion. I suppose what I am asking is, is there an inevitable contradiction between the moral right and the practical argument or is it possible to pull them together?

Mr O'Reilly: It is interesting because, in terms of the United States at least, many of the proponents of some of the moral strictures on the use of US funding, including the prostitution law to go for an abstinence earmark, were also the most vocal proponents of extra funding for HIV. On the one hand you have Senator Santorum saying, "We have to enforce the constitution loyalty oath and we are forcing organisations that are in receipt of US funds to sign a declaration that says they oppose prostitution", which I think is very problematic for some of them and I will return to that in a minute, but on the other hand sponsoring the amendments in the Senate to increase contributions to the Global Fund, and he did both of those things undeniably out of his Christian conviction, so I think in some ways they come together in terms of the need to respond at a human level to the imperative of HIV, but unfortunately how you do it in respect to the moral and ethical questions *vis-à-vis* sex does risk becoming extremely problematised. In respect of this very question those strictures on the part of US funding are highly problematic. I am not sure whether or not abstinence and the programming empower women to say no to sex but what it definitely does is stigmatise condom use where you have programmes being funded by the US that say abstinence is the choice that you should make, except if you are a sex worker or a man who has sex with men, in which case you should use a condom, which immediately suggests that anyone who uses a condom falls into those immoral groups. It is highly problematic in terms of creating a popular culture of safe sex and of universal precautions. What we should be doing is encouraging everyone who is having sex to have the information and the skills and the support to make decisions about their sexual practices which are safe. Promoting abstinence only and restricting people's access to the information and the commodities, such as condoms, that enable people to make those decisions and have the resources to exercise them, is highly problematic, as is the prostitution loyalty oath which forces organisations who are working with sex workers to say that they oppose sex work. It is not as though organisations support sex work but in order to work with sex workers they often have to take a non-judgmental approach, and in order to do that it is a bit contradictory to suggest that they have to oppose sex work on the one hand but on the other hand work in an open and honest way with their clients, who are often sex workers.

Mr Mulji: We have absolutely no evidence that abstinence-only education would work, for example, around male-to-male sex. We have evidence that suggests that it would be counter-productive. We often work with very marginalised men who are often undertaking sex work in public sex environments at parks and railway stations and railway tracks, who specifically go to those places to have sex. If we start talking to them and saying, "You should not be having sex", number one, they went to that locale to have sex and we are immediately going to be alienating them in our opinion. Secondly, I think there is a problem with US funding and at least a perceived notion that you have to promote abstinence. I have seen a leaflet published by an organisation in south east Asia around male-to-male sex, and the first message it says is, "The first thing you should think about is not having sex", but the rest of the leaflet is actually very good. I talked to this group and said, "There is no evidence that abstinence works so why have you put it on the leaflet?", and they said, "Because we get funded by the US Government. We have to talk about abstinence". I said, "There is no evidence that it works", and they said, "We just put it there on the front of the leaflet". There is no evidence it works and we strongly believe it could be counter-productive.

Dr Chatterjee: At the national level it could be put together. If we look at Malaysia and Iran these countries have very conservative, strict drug laws, but because of their HIV epidemics and the emerging reality of HIV epidemics both those countries have been able to develop harm minimisation programmes, condoms in prisons, methadone. Sex work in Thailand is technically illegal but that has not stopped Thailand from rolling out a large HIV programme for sex workers. Many countries have found ways of addressing the moral and pragmatic considerations and have been able to put together decent and large-scale programmes. But it will be diverse, it will be taking different shapes in different countries.

Q14 James Duddridge: When looking at abstinence and condom use what was the experience in Uganda? Was that a good case study of proof that it does not work, going back to abstinence after a successful condom programme, or have I been misled?

Mr O'Reilly: No, I think that is absolutely right.

Chairman: Have things gone down? Have the figures moved in the wrong direction?

Q15 James Duddridge: My understanding was that AIDS was coming down in Uganda and there was good condom use and good discussion of AIDS related subjects, and then there has been a trend, for whatever reason, towards more of a purist abstinence viewpoint and AIDS rates have gone up.

Mr O'Reilly: That is absolutely right, the general history which you talk about there. One of the challenges that we have with respect to rates and looking at an epidemic and its course over a period of time is the question of attribution. There is a debate internationally at the moment, in respect of Uganda, as to whether or not we can link the increasing HIV incidence rates that have occurred

recently in Uganda with a less than full commitment to condom promotion, but certainly Uganda was held up internationally as an example of what needs to be done using an ABC approach which was "Abstinence, Be faithful and Condoms". All of those things in Uganda at the time that it was held up as an example were treated equally and they were all genuine options for people and were presented as such. What has happened in Uganda, and there is lots of evidence to suggest this, is that the promotion of condoms has diminished, and there is certainly lots of discussion about how that has happened and why, what has influenced that, and there is a very useful Human Rights Watch report which I have encouraged the Committee to refer to, called *The Less They Know The Better*, about diminution in condom promotion in Uganda and the links to US influence in respect of that.

Q16 James Duddridge: What is the pre-eminent research in terms of the key populations and the interactions between the key populations that you are talking about? For example, are these marginalised groups completely isolated or is the man that has heterosexual sex with a sex worker also an injector or a prisoner who has male-to-male sex? What is the overlap or do we not have that information?

Dr Chatterjee: There are constant interactions between the groups because in most parts of the world where we have emerging epidemics of HIV, for example, among men who have sex with men in Asia, many of them are married and have regular sex with women. And there are clear data from several national programmes to show that. There is a huge turnover of prisoners in every country all over the world; it is estimated that about 30 million people go in and out of prisons globally in a year. Most people stay for a short duration in prison. Prison is a very high risk context for acquiring and passing on HIV, and prisoners come out and interact with the general community, so HIV prevention within prisons has clear-cut public health implications for HIV prevention in the general community. Similarly, in a lot of countries in Central Europe, Eastern Europe and Central Asia, Vietnam, a significant proportion of sex workers also inject drugs. There are empirical data from national surveys which show different overlaps between different groups and with the general population at large. Better mapping of these risk profiles and risk behaviours will make us understand about the drivers of the epidemic I was talking about and thereby fine-tune our intervention in terms of intervening at strategic points.

Q17 Chairman: We are running out of time. We started a bit late and the Minister is waiting and so we may have to draw it to a close. Just on the point that Mr Duddridge has made, can you say whether the international donors and other agencies have been successful in involving these groups themselves in the policy-making process in the countries, because one of the things that you have all been saying is how their views do not really appear to be taken into account because they are excluded, because they are illegal or whatever it be. What success is there in ensuring that they do have an input into the policy of national programmes?

Mr Mulji: There is not with the international community. I think there is sometimes at a country level, and I cited India as a good example, but if we take, for example, the Global Fund to fight AIDS, TB and Malaria, which is a multinational fund, there has been in my opinion a very poor involvement from the key communities. For example, in India, Bangladesh, Nepal and Pakistan there has been very little involvement with those key communities in helping develop proposals. There are examples around drug use where drug users have had to go outside the country co-ordinating mechanism for funding, so I think there has been a failure to engage some of those communities, partly because they are very bad at advocating for themselves. Some of the males we work with were never organised until we came along and helped them set up community based organisations, so there has been no-one to advocate for them. There is also a very closed-shop attitude in some countries where there are some very well known, linked-in-with-government NGOs who are very powerful voices to the exclusion of other NGOs, so I think the politics is a very big issue about who gets a voice and who even gets in there. I think it has been very patchy and I do not know whether the government has really supported getting civil society to talk to governments and multinational agencies.

Mr O'Reilly: It is important, Chairman, to take that work to scale. It is quite ironic. One of the things that we did, and it was a success of the international community's advocacy, was that we convinced the Global Fund to change the rules about the composition of country co-ordinating mechanisms at the country level, so the country co-ordinating mechanism included representatives from civil society that was most affected by the epidemic in that country, so in many places like Cambodia, Ecuador, *et cetera*, where we were working, it required the country co-ordinating mechanism to have sex workers and men who have sex with men, injecting drug users on it. The problem was, of course, having advocated for that, that in many places there were not organisations and individuals who were sufficiently capacitated for that role, and that is I think where the real work is, supporting those community organisations, and we need to be in that for the long haul. We talk about scaling up HIV prevention and treatment and services, and at least at a rhetorical level we pay lip service to the fact that the communities are key to the provision of those services and to accessing them, but one of the things that more often does not follow is any resources to allow those communities to mobilise and organise themselves so that they are able to play a useful role. One of the things I have left with the Committee this afternoon is a publication[4] which we are launching later today at the Commonwealth Club, which is the

[4] International HIV/AIDS Alliance/Frontiers Prevention Project, *Unheard Voices, Hidden Lives: Stories from the frontiers of the HIV epidemic*, http://www.aidsalliance.org/sw40083.asp

result of a participatory photo project in Cambodia, India and Ecuador in which members of those key populations—sex workers, people living with HIV and men who have sex with men—took photographs and detailed their experiences, their lives, their aspirations and their hopes, and it is part of that project that I alluded to before in Cambodia that we have been implementing with the Blue Moon Fund and the Gates Foundation. This in a sense is an antidote to the invisibility and the silencing which we have been talking about today, and in each of those places we are not only supporting this sort of initiative but also all the individuals who are participating in this project come from community organisations that we have been supporting. We believe that is where the real work is because without their visibility, without their voice, the programming and the decision making which we make on their behalf will not meet their needs, or it certainly will not have as good a chance of doing so unless we hear from them and see them. They have to be at the table and that is what this initiative was partly about addressing.

Chairman: Thank you all very much. As I say, I am sorry for the late start, but it has been extremely helpful. It is obviously a complex issue and clearly setting targets is one thing but finding policies that will actually deliver them is a wholly different set of issues. You have really helped us to move down that road and we now have the opportunity to ask the Minister some questions, which I have no doubt you will be listening to as well. Thank you, all three of you, very much.

Witnesses: **Mr Gareth Thomas,** a Member of the House, Parliamentary Under-Secretary of State, **Mr Andrew Rogerson,** Head of Human Development Group, Policy and Research Division, and **Ms Robin Gorna,** Senior AIDS Adviser and Team Leader for Global AIDS Policy, Human Development Group, Policy and Research Division, Department for International Development, gave evidence.

Q18 Chairman: Minister, thank you very much for coming in. I apologise for the change in plan. As you know, we have re-scheduled this particular session a couple of times and this is not the easiest week to co-ordinate everything, but it does not in any way detract from the fact that we think it is extremely important that we have an annual review of how we are doing as a country in delivering the ambitious targets on ultimately the fight against HIV/AIDS. I should at this point record that the former member of this Committee Jeremy Hunt's contribution to focusing on the need to have annual targets and this annual review that we are having is part of that process, and that is one of the issues we want to discuss with you, although the evidence we have just had demonstrates that targets, as we all know, are one thing but finding the policies that will deliver those targets, particularly when working in a whole variety of different countries, is something else. Having read your submission, it gives a lot of detail about the very good work that the Department is doing on a whole variety of programmes in a whole variety of countries but it still does not have any indication of what your benchmarks are and what your targets are other than in funding. You are quantitatively saying that you are putting all this extra money in but you are not actually saying, although I can read that there are an awful lot of good initiatives, how you are setting your agenda. Are you going to be doing that, and perhaps, because I have been discourteous, you should introduce your team before you answer the question so that we have that formally on the record?

Mr Thomas: Mr Bruce, I wonder if, as well as introducing the two officials with me, I could just say a very short word by way of introduction. You asked me to introduce my officials. Andrew Rogerson is the Head of our Human Development Group within the Department, and Robin Gorna, within that group, heads our AIDS team. Just by way of a short introduction, and perhaps with Jeremy Hunt's memory in mind, let me say that I think the single most significant event in the fight against AIDS over the last 18 months has been the agreement that was first initiated at Gleneagles and then was taken forward by the UN, particularly the UN General Assembly in June this year, to draw up plans for as near as possible universal access to treatment, prevention and care. I understand through UNAIDS that over 80 countries have set some targets so far, that over 40 of those have a series of targets in key areas and that 20 of those countries are at the moment moving forward with costing their plans. Work on those plans is continuing, in particular to ensure that the needs of marginalised groups, such as men who have sex with men, injecting drug users, sex workers, are properly recognised. Among the key challenges over the coming 12 to 18 months will be to continue to put in place the finance so that these plans can be implemented, and, secondly, crucially, I think, to strengthen the technical assistance, particularly through the UN, to ensure that these plans are delivered effectively. In terms of answering your question: should we put in place our own separate targets for how our aid money delivers results on AIDS, I do believe that we should be able to understand the results that our money is achieving, but I think the targets for the response to AIDS must be country owned and they must be put in place by the country. Ideally they should be targets which the whole of the donor community in a particular country endorse, whether they are interim targets or whether they are the ultimate targets. I think we can show how our programmes have made a difference, and I am happy to go into some detail for the Committee if you would like, but our approach is not to have separate targets ourselves but to come in behind the targets that countries themselves set. I recognise that is different, for example, from the

approach that the American PEPFAR Initiative takes, but I do believe that our approach is appropriate.

Q19 Chairman: Thanks for explaining that and I think that is a perfectly reasonable position. The only comment is that, reading the submission, which, as I say, does summarise a lot of clearly very good, very appropriate and very leading initiatives that DFID is taking; I would not want to detract from that at all, but it still raises the question that the only quantitative information is how much money has gone in, and even if it were not so rigid as a target some kind of evaluation of the effect of DFID's involvement towards the wider targets would seem to me to be worthwhile in terms of even engaging the public, saying, "What is the British Government's contribution to achieving the international targets?". Is that something you feel you could consider?
Mr Thomas: I think it is perfectly reasonable that the Committee and the public at large should want to have confidence that our aid money is delivering results. We will be completing an evaluation of our AIDS strategy; we are working through that at the moment, which I hope will give a collective sense of how our money is making a difference. We also have the opportunity through, for example, our country systems plan process, to look at a whole series of our interventions in particular countries, including interventions to tackle AIDS, but again let me say that we can demonstrate where we have had an impact and we have also examples where we have set targets and where we are making progress on those targets. The crucial thing about those targets is that they are country owned. One example which I think the Committee will be familiar with is Malawi, where we have put £100 million by way of investment into the health sector, which obviously will help in the fight against AIDS, and the approach over the next five or six years is to see a doubling in the number of nurses and a trebling in the number of doctors. We are increasing the pay of nurses by some 50% to help achieve that, and since April this year, and it is too early to make general conclusions, I understand that some 700 nurses who had formerly left the health sector in Malawi have returned. That I think is an example of results. Obviously, it is not AIDS specific, but increasing the number of health workers is crucial to improving the response to the fight against AIDS in Malawi and indeed elsewhere.

Q20 Chairman: In response to that, the Committee did obviously hear about that programme when we were in Malawi and it is very encouraging to hear that it had that effect. Is that a net figure, in other words that 700 returned? Are they still leaving as well or have you managed to stop that process?
Mr Thomas: My understanding is that the numbers leaving have dropped to a trickle. I did add a rider, that it is a bit early to make conclusive judgments, but certainly the initial evidence is encouraging.

Q21 Chairman: That is helpful. You have said that you are in the process of reviewing and evaluating where you are at. Is this likely to lead to a stated change of response? Having done the review are you likely then to say, "We have evaluated it and on the basis of this we are going to have to change or reprioritise"? Is that the objective?
Mr Thomas: One thing that the Secretary of State and I have both acknowledged previously is that we need as a Department and as Ministers to be better at demonstrating results about aid programmes. We are confident internally that our aid programmes on AIDS as well as across a variety of other spectra are making a substantial difference. I recognise that the House has asked a number of times for us to give further information and further clarity about the results that we are having. I think the evaluation will help with that but the whole point of having a review under way is so that we have a look at the full range of the work we are doing and come to some conclusions at the end of that review process.
Chairman: That is why I have not asked you the question that is down here, because I thought you would answer in that way.

Q22 James Duddridge: For the record, I have replaced the late Jeremy Hunt and, as was described, he has moved onto the Front Bench of the Conservative Party, which is hopefully a fate better than death.
Mr Thomas: I would think that is relegation or demotion.

Q23 James Duddridge: Minister, you will find me equally passionate about AIDS, particularly in sub-Saharan Africa where I spent much of my career before coming to the House of Commons, but increasingly the geographic reach of AIDS is moving away from sub-Saharan Africa. How is the Department coping with that geographic move, particularly in relation to the epidemic in Eastern Europe and Central Asia?
Mr Thomas: I think you are right to highlight that whilst the numbers and proportion of the population in Africa are particularly high in terms of AIDS, we face rising problems in Asia, in Latin America and the Caribbean, and indeed in Eastern Europe. My understanding is that on current trends the numbers of people as opposed to the prevalence rates in Asia will be higher than for Africa by 2010 if things do not change. HIV/AIDS is an increasing part of our discussion with the various countries that we work in, Asia, for example. If we take India as one example, we have a £123 million programme through to next year under way. We are working in some eight states, in particular looking at the needs of marginalised groups in those states, and our interventions have helped the Indian Government to scale up their AIDS programmes to support the needs of those marginalised groups. Given the original focus, as I understand it, of this inquiry, I think it is particularly appropriate to say that in Asia at the moment the epidemic is predominantly concentrated among the groups that I have described—sex workers, men who have sex with

men, injecting drug users and prisoners, and it is there that we need at the moment to concentrate our response, and we are working, as I say, with a variety of governments to do just that.

Q24 James Duddridge: It is particularly worrying in India given that that sounds like the early stages of the epidemic before it spreads much more widely and quickly. More generally, how flexible is the funding and planning of DFID to a new epidemic within a region? We have heard a lot about the key populations and there seems to be the potential for an epidemic to take part in a new part of the world and drive forward pretty rapidly because of the nature or concentration of those key populations.
Mr Thomas: AIDS is an issue in every part of the world and in the countries where we have an established tradition of working it is part of the dialogue that we have with countries. For example, in the Caribbean we have an AIDS programme. In particular we are working with the private sector in the Caribbean because of the tourist trade, for example, and indeed to make sure that we are explaining to people what they need to do to protect themselves from HIV infection and to look at the contribution that business could make there in helping to get those protection messages out. We are working in Latin America, for example, with centres which UNAIDS have set up in Brazil, looking to spread best practice across the region, and our harm reduction programmes, for example, in Serbia, have been used as a model by the government for scaling up their harm reduction work across their country. Similarly, we have had effective work done in Ukraine, which again has influenced the government to take forward that work and tackle harm reduction initiatives.

Q25 Mr Davies: Mr Thomas, I gather that the Government have set up a cross-Whitehall HIV/AIDS Cohesion Group, I think it is called. Can you tell us how often that group has met and when it last met?
Mr Thomas: I will bring Ms Gorna in to tell you the specifics of when it last met, but it discusses a whole range of issues from the extent to which AIDS is a topic for G8 presidencies to the policy we should be asking our G8 Sherpa to be articulating to other G8 Sherpas. We have discussed the evaluation and process for our aid strategy at that working group. When we develop a new policy, for example, we developed a policy last year on harm reduction, that was discussed within that working group. I will now bring Ms Gorna in to give you the specifics about when the committee last met.
Ms Gorna: The cross-Whitehall Working Group on AIDS meets three times a year, so the next meeting will be in January. We had a meeting two months ago. It brings together the Ministry of Defence, the Foreign and Commonwealth Office, the Department of Health, the Home Office, the Department of Trade and Industry, the National Audit Office, the Treasury, Revenue and Customs, the Patent Office, the Scottish Executive, the Welsh Assembly and the Northern Ireland Assembly, and the Department for Culture, Media and Sport is also joining. In addition to the areas the Minister mentioned we have also been looking at workplace policies across Whitehall and also at the Access to Medicines Agenda which has its own separate focus within the group.

Q26 Mr Davies: Gosh! How many people do you have round the table when you meet?
Ms Gorna: Quite a few. We often have about 20 people round the table.

Q27 Mr Davies: What difference has this group made? What has been achieved which would not in your judgment have been achieved without it?
Mr Thomas: One of the issues, for example, that we need by way of support is the active involvement of all our embassies on occasion to get messages across in the run-up to UN General Assembly special sessions on AIDS, where there was an intense debate about the language that we needed to include in the outcome document from that statement. That was one of the issues that was discussed at the Whitehall meeting. It helps to make a difference in galvanising discussion and, on occasion, galvanising the activity of other departments when it is appropriate in the work that we seek to do.

Q28 Mr Davies: You have not actually answered my question. I did not ask you what sort of matters were discussed. I asked what the group had achieved. You do not need the presence of people from HM Revenue and Customs and from the Patent Office in order to talk to the Foreign Office. You have a whole range of interfaces with the Foreign Office right across the globe. What actually has been achieved as a result of the constitution of this group which in your judgment would not have been achieved had that group not existed?
Ms Gorna: Perhaps the most significant issue, which I think was mentioned in the previous evidence session, is the harm reduction policy. That is a cross-Whitehall policy clarifying the approach to injecting drug users and ensuring that we have a coherent whole-of-government approach across the Department of Health's work within the UK and our work internationally, and that is not the case with some other governments. My understanding is that through the efforts of the FCO and others that has also enabled us to interface most effectively with the UN agencies concerned with drug use and harm reduction. That was launched on World AIDS Day last year and has been used extensively by other governments and by the UN as well as by ourselves to drive that forward. Secondly, in terms of our engagement on the G8 and in the EU, we have had a common position across government that has been achieved through that group.

Q29 Mr Davies: It is my impression, Mr Thomas, purely a personal impression, that in those areas of the world most affected by AIDS, in Africa and Asia particularly, there has been a considerable failure of leadership by local politicians in addressing the issue, a great reluctance to talk about the issue, and

an attempt to cover up when prominent people die of AIDS which we would hope might have a shock effect if due publicity was given to it. Sometimes, frankly, deplorable misguidance is given by leaders, and I think Mr Mbeki's statement some years ago that he thought there was no connection between HIV and AIDS was particularly deplorable. I wonder to what extent you, the Secretary of State or your Foreign Office colleagues, in private conversation with politicians in those countries have been able to persuade them to look again at the case for a rather stronger degree of leadership being given by local politicians on this issue.
Mr Thomas: I think to say that there has been a failure of leadership by all politicians in the most affected parts of the world is unfair.

Q30 Mr Davies: Please do not distort my question by rephrasing it in an absolute way in which it was not actually formulated.
Mr Thomas: Okay.

Q31 Mr Davies: If you would just answer it I would be very grateful.
Mr Thomas: You referred specially to South Africa and I will answer the question about South Africa. I think there are examples in many parts of Africa where there has been significant political leadership, leadership from the very top. The President of Malawi, for example, has spoken out on AIDS and a series of other cabinet ministers, for example, in Malawi have spoken out.

Q32 Mr Davies: Would you agree with my characterisation of President Mbeki's remarks on the subject?
Mr Thomas: They were comments that I certainly did not agree with and I welcome the change of policy that appears to be taking place in South Africa. I would pay tribute to the work of a whole group of NGOs in South Africa who have led the effort to try and get the policy changed.

Q33 Mr Davies: My question did not address NGOs.
Mr Thomas: You also asked whether we had done anything.

Q34 Mr Davies: I asked whether you took advantage of the opportunities to have private conversations with politicians of these countries to raise this matter—
Mr Thomas: Yes, we do.

Q35 Mr Davies:—which is probably most effectively raised informally.
Mr Thomas: Yes, we do take the opportunity to raise these issues both formally and informally. Our Ambassador in South Africa made a series of representations to President Mbeki and his government on this issue. I know the Secretary of State has raised these issues many times formally and informally. On occasion, when I have gone to countries in Africa I too have raised those issues and I have certainly raised those issues in the countries that I have been to in Asia as well.

Q36 James Duddridge: Earlier we discussed Uganda and the increase in AIDS after quite a successful ABC regime and then the move towards just abstinence. Is the increase in AIDS resulting from a reduction in the promotion of condoms in Uganda something the British Government has been able to raise with Museveni?
Mr Thomas: I need to check on the specifics about the conversations that we have had with President Museveni but we have certainly made clear that we want to see a continuing increase in the availability of access to condoms. I think we have made clear many times that whilst there is a role for encouraging and supporting messages to particularly children and young girls, supporting them to be able to resist starting sexual activity at an early age, bluntly abstinence as a policy in our view does not work, you do have to recognise the reality of today and what some people might want to see as the practice in particular countries we need to recognise is not the reality and we need to put in place the policies to deal with that reality, which is why trying to increase access to condoms is very important. Frankly, the figures for access to condoms in Africa are deeply concerning. At the moment there is an average of just eight condoms available per adult man in Africa which is a ridiculously small number. We do need to do more to increase the availability of condoms and that is something we are working on with UNFPA[5] and other bodies.

Q37 James Duddridge: Will you be able to write to the Committee specifically relating to the issue of to what extent these representations are helpful? President Museveni and his family are particularly influential in this issue and it would interest me to learn what representations you have been able to make on behalf of the British Government.
Mr Thomas: I will be happy to provide the Committee with exactly that answer[6].

Q38 Mr Davies: If I may say so, Mr Thomas, my own impression is that the main problem in Africa is not so much access to condoms, although that may be a problem in some cases and certainly one that we should address, it is inclination to use condoms, it is motivation to use condoms. I think that is the biggest problem of all. I wonder whether there is any way in which you think that issue can be addressed. Obviously it can be addressed only by education, by PR of various kinds, and the main role must be played local governments, it is not something which can be imposed from outside, the message cannot be effectively delivered from London or Geneva or New York. Are there any comments you would like to make on that?
Mr Thomas: I agree with you that education is as important as availability and local governments have got to take the lead. There are things as donors that you can do. We do support, particularly in South Africa and it is now being rolled out across southern Africa as well, what is called an "edutainment" programme, *Soul City*,

[5] United Nations Population Fund
[6] Ev 29

which seeks in a very populist way to get across messages about AIDS and how to prevent yourself being infected with AIDS. Through popular media and through funding popular media we can get prevention messages across. You are right, the leadership has got to come from local governments—donors can only support local governments—if we are really going to make a difference on AIDS. Perhaps the one caveat is the issue of Zimbabwe where there is not good political leadership, as you, Mr Davies, and the Committee will know, and where there is nevertheless a responsibility on the international community to do as much as we can to get both prevention messages across and improve availability of services. The Secretary of State recently approved further funding to Zimbabwe to try to continue to make a difference in that country. We have seen a reduction in increasing prevalence in Zimbabwe and that certainly is not down to the leadership of the government at a local level, it is a result of the international community working together with a series of quite brave NGOs and people committed to this agenda in Zimbabwe.

Q39 Mr Davies: Yes. I spent a very disturbing afternoon a couple of years ago with about 40 or 50 prostitutes in Nairobi, all of whom were HIV positive, none of whom were receiving anti-retrovirals or had any prospect of receiving them, all of whom were therefore dying and knew it. I had quite a frank discussion and asked them why they had not used condoms and universally they said, "Our customers won't accept it" or "I needed to feed my family and I was only going to be paid a reasonable amount of money if I did not use one". They all knew perfectly well why they had ended up with HIV and the problem was the one that I have just stated. It has occurred to me for a long time that there is probably as much promiscuity or commercial sex in any part of the globe as there is in Africa, the difference is not the level of sexual activity, it is the use or non-use of condoms. I think the Government is right to put great emphasis on that. If I may say so, trying to encourage people to use them is probably even more key to solving the problem than making the things physically available.

Mr Thomas: While I agree with you that education is absolutely fundamental I think your example of the conversation that you had in Nairobi raises another issue where we are working, and in a sense that is supporting groups such as sex workers to come together to understand, first of all, the issues you have just described and, secondly, to work together on encouraging the clients who come into the areas that they are living and working to use condoms. You might initially think that is too difficult but we have funded for some time a clinic in the Sonagachi area of Calcutta, which is a very similar area to the area that you describe in Nairobi, and as a result of the peer education work that that clinic has inspired the level of infection among the sex workers in Calcutta is dramatically lower than in other cities in India where that work is not as advanced as it is in Calcutta. There are reasons for optimism. There are programmes that do work around the world, but I accept your point absolutely that education is key to making progress on it. What I do not think we can say, and I accept you are not saying it, is that we can relax on the issue of availability.

Q40 Mr Davies: No, of course. Clearly there is no point in making people inclined to use them if they are not available. I do think that the really tough nut to crack is the inclination to use them. Let me finally give you a bouquet, if you would like that, for DFID this afternoon. I thought you were absolutely right to support paying nurses more and trying to increase the supply of nurses in Malawi. We were there, as you know, earlier this year and we visited one hospital which I recall very clearly which had one qualified doctor. He was absolutely brilliant and doing a fantastic job but he was also the director of the hospital and trying to diagnose the patients. There were four qualified nurses, 400 beds and somewhere between 600 and 800 patients. I think just saying that gives you an indication of the conditions in which those patients were. A number of them, of course, were HIV positive, I do not remember whether we had a figure for that, perhaps the hospital did not know itself. The need for qualified medical personnel is absolutely key in these areas.

Mr Thomas: Mr Davies, thank you for that, and perhaps by way of trying to return the favour let me try and give you some sense of optimism about Nairobi. One of the things that we are doing is to fund through the National AIDS Commission in Kenya a network so that sex workers can come together to get support to start this type of peer education work that I have described is happening elsewhere around the globe. It is a start and there is a lot more to do, I accept that.

Q41 Chairman: I think Joan Ruddock will want to develop that point but I just want to ask a question first. We raised this matter last year, which continues to be a matter of concern, which is how we treat asylum seekers in this country who are HIV positive. First of all, if they are failed asylum seekers we understand that it is still the case that they have to pay for treatment. Can I ask if that is the case? I know it is not directly DFID's responsibility but it does not help DFID's appeal to the wider world and the desire to eliminate it if we are pursuing policies in the UK that do not seem to quite fit. Is it still the case as far as you are aware that failed asylum seekers have to pay? What happens if they cannot afford to pay? What steps are taken when they are being returned to their communities that they are not actually being sent back (a) with their own human rights challenged in terms of continuing treatment if they are getting it here, and (b) the circumstances in which they might well be sent back to re-infect the population from which they came? Is DFID taking any initiatives across government to address those issues?

Mr Thomas: Those issues, as you describe, are probably the responsibility of the Department of Health.

Q42 Chairman: Well, I accept that but you take my point that they do rather undermine international development if they apply.

Mr Thomas: I am not sure I do. Let me try and explain the policy. My understanding is that asylum seekers are exempt from charges for hospital treatment, including anti-retroviral treatment for HIV infection, as long as their application is underway. My understanding is that if a course of treatment has started before their application is rejected then until they leave the country their programme of treatment can continue, but there is an issue about payment, as you rightly say, if they want to start a course of treatment after their application is rejected. I am happy to check that and if I need to give you further clarity I will do in a letter.

Q43 Chairman: Can I press the difference of opinion that you do not accept the point. First of all, just in terms of the UK Government's credibility challenging the world to try and eliminate it if we are pursuing domestic policies at home which do not seem to be consistent with giving everybody access and putting them into limbo, do you accept that is not consistent with the overall objective? My second point is we may well be returning those people once they are finally deported back to the country with an HIV infection for which they personally may not be able to get treatment and where they will help to re-infect people in the country where they came from. I am surprised you say you do not accept that cuts across the development strategy.

Mr Thomas: There has to be a balance, Chairman, between the needs of an individual who is HIV positive and the overall need to ensure that we have a strong immigration system in place. I think, broadly speaking, we have got that policy right. As I have indicated, I am happy to check the detail of the answer I have given you.[7] What I do think we have a responsibility to do very much so still is to scale up access to treatment. We have got a responsibility to scale up access to prevention and care as well in the countries where there is not enough availability in that area. We have seen in recent years a substantial increase in access to anti-retrovirals in many countries but I will accept that there is a lot more that we need to do.

Q44 Chairman: I am afraid that answer is slightly consistent with the argument we had in the previous evidence session of the difficulty one has in persuading a number of governments to deal with marginalised groups because they are perceived to be outside the law or criminal or in some way have been deemed to be antisocial. If I may say so, we seem to be using an argument that sounds rather similar.

[7] The witness has confirmed that this is accurate.

Mr Thomas: What I would point to, Chairman, by way of response is the encouraging figures that there are about access to treatment. There has been almost a doubling in the numbers on treatment in 2005 in sub-Saharan Africa. The numbers have increased eight-fold between 2003 and 2005, up from 100,000 on treatment in sub-Saharan Africa to some 810,000. I think there is much greater international community recognition and, indeed, domestic government recognition of the need to increase access to anti-retrovirals and it is right that the focus is in-country rather than, if I may say so, looking at the particular issue from the domestic immigration control end.

Q45 Joan Ruddock: Just on the point that you mentioned, which is access to anti-retrovirals and those who are in treatment, I wonder what kind of long-term follow-up there is going to be to answer the question how effective the treatment is. I must say that I was as thrilled as everyone else around this table who visited Malawi to hear the success of the support for professionals in Malawi, but one of the things that we learned was although the drugs might be available it is incredibly difficult to run the regimes of constant testing to ensure that the drugs are given appropriately to increase the survival of the patients. I think that it would be very useful to know how ultimately we are going to measure this. It may be that drugs become available, people get given them initially, but the health systems are not sufficiently robust to see the process through.

Mr Thomas: I think the first thing to say is that there is research underway being led by the World Health Organisation to monitor the effectiveness of treatment regimes. I think it is relatively obvious that if we cannot increase the number of health workers, which was Mr Davies' point, we are going to have real difficulties in helping to keep people being tested and supported through that process and getting access, particularly if they live in rural areas, to the anti-retrovirals in the first place. Part of the discussions we are having now internally looking ahead to our bid to the Treasury under the Comprehensive Spending Review is whether or not there is more that we can do in a variety of countries around health workers. There is then the issue about improving through the research funding we get the quality of the diagnostics and improving the efficacy of the anti-retroviral treatments, particularly issues around access to paediatric anti-retroviral treatment, and we are working on a number of fronts as a result to try and deal with those issues too.

Q46 Joan Ruddock: I think that would be very welcome and I am sure we would like to hear more about that as the programme unfolds if you are successful in your bidding. I want to return to the marginal groups that you mentioned at the outset today. The UNAIDS four key populations appear, from most of the evidence we have got, to be central to tackling and halting emerging epidemics. In your own evidence, if I can just quote you, you said:

"There are . . . both human rights and public health rationales for countries facing emerging epidemics to take immediate action to reduce vulnerability to HIV in marginalised groups." I think it is well recognised that the UK has linked human rights with marginalised groups with HIV treatment and access to programmes, and this has been very much applauded in the evidence that we have had from NGOs and contrasts, I think, from our own experience certainly with the more moralistic approaches of particularly the United States. My question really is to what extent can that leadership role which DFID has already had be expanded? Do you see that there are any ways in which there should be new international forums, especially UN human rights forums, which DFID should directly address in terms of the HIV/AIDS programmes?

Mr Thomas: Well, as you say, we have tried to take a lead in a series of international forums, for example the Board of UNAIDS in terms of the Harm Reduction Policy debates that have taken place in the last 12 months, also during the UN General Assembly discussions on AIDS to make sure that the needs of marginalised groups were heard. In the end the real difference is going to happen at country level. We have to persuade political leaders, which was Mr Davies' point, in a sense to lead that change. One of the things that we can do as ministers in discussions that we have is to make the case for that change. I have responsibility for the Caribbean and I have made the case for change in laws in the Caribbean which help to stigmatise people who are vulnerable to HIV infection or, indeed, who are HIV positive already. We have supported that direct face-to-face advocacy with programmes that seek to bring in a range of cultural and sporting personalities to deliver positive role model messages about HIV prevention issues. For example, we have got a further programme working with the media in the Caribbean to take place in December, again hoping that through the media we can change the attitude of journalists to some of these issues and help to get the issues covered in a more sensitive way. I think it is at country level where the change has got to come. International forums in a sense help to create the right mood for the decisions, they help to create the right policy documents on occasion in the right policy context but it is at country level where the change has got to come where advocacy is needed both from ministers going into a country but also from people in-country. We seek also to support HIV positive groups themselves to make the case for change in their country.

Q47 Joan Ruddock: I wonder if you might include business as well. You did not mention business but I hoped you would because I remember meeting business people from Debswana in Botswana and they had very good programmes for their workers but, of course, no programmes for the sex workers who their workers were having contact with and, indeed, they denied the fact that the sex workers were around the plant at all.

Mr Thomas: In the Caribbean, just to go back to the previous example I was giving, we work directly with the business community in the region. There are a number of international business people and business organisations who have given a very powerful and very strong lead through the Global Business Coalition, for example, around workplace policies, on occasion giving money to the Global Fund and on occasion through the wider prevention messages that they give. As an international community we have to continue to work with business, with sporting personalities, with cultural figures to help get these HIV prevention messages out not only to marginalised groups but also to make sure that, in a sense, the wider population feels comfortable with these messages.

Q48 Joan Ruddock: Does your reply about it being more a country based issue rather than United Nations and forums of that kind mean that you would reject a proposal which has been made for a UN Special Rapporteur on HIV/AIDS and Human Rights, which was one of the suggestions that NGOs submitting evidence to us made?

Mr Thomas: I would not reject it but I would point to the fact that the UN Secretary-General has already appointed a number of special envoys on HIV and AIDS. Stephen Lewis, the—

Q49 Joan Ruddock: If I may interrupt, Minister, I think it is the connection between HIV and human rights which is the distinction being made here.

Mr Thomas: I accept that. What I would say is those envoys have made on occasion a series of interventions around the linkages between human rights and AIDS, both in Asia and in Africa, where I know Stephen Lewis has been particularly strong on this issue. I think we would need to look at what has already been established and the extent to which this issue is not already being covered. As I say, at the moment I think the envoys who have been appointed are doing a very good job in these areas. I accept it is something that we need to keep under review.

Q50 Chairman: Just on the back of that, in the UNAIDS report, which was published in May, they said, particularly talking about women in this context: "Women must be adequately represented in policy and decision-making on AIDS" and then it quotes that a 2004 UNAIDS assessment found that, "Women participating in the developmental review of the National AIDS Framework was non-existent in more than 10% of 79 countries and inadequate in more than 80%." Has that situation improved? Does DFID have any particular strategy for it? On the back of that I think James Duddridge may have a specific question.

Mr Thomas: It does relate to the question about human rights and the way in which women are perceived in many of the countries in which we are working where AIDS is a significant issue. I would like to be able to say to you that the situation has dramatically changed but I do not think it has as yet.

One of the things that we seek to do in our aid programmes is support the ability of women to make their own case in-country and in the direct conversations that we have, the Secretary of State and I, we advocate for change in terms of the position of women in society and, indeed, for women's groups to make sure that they are heard within debates about AIDS policy in-country. I think the situation is one where we still need to see radical change, frankly.

Q51 James Duddridge: The Prime Minister in the foreword to the UK's strategy on HIV and AIDS singled out women, children, orphans and older people at the heart of the AIDS problem who, in his words, "bear the brunt of this global disaster right at its heart". What specific concerns do marginalised groups seeking access to treatment have, these marginalised groups specifically, and how successful has DFID been in addressing those problems and what metrics have you got around success rather than inputs?
Mr Thomas: In China, for example, the epidemic is overwhelmingly concentrated amongst marginalised groups at the moment and some of the targeted interventions that we have made in China have been recognised by the government for the difference that they have made and the government are now taking on those changes and seeking to replicate those policies across the whole of the country. The example that I gave of the clinic in Sonagachi in Calcutta has now been taken forward by the Government in India and they are seeking to replicate that work across India. Some of the work that we did around harm reduction in Serbia and Ukraine has been recognised by the governments in those countries for the difference it made and, again, they are seeking to scale up the work we have done across the whole of their countries.

Q52 James Duddridge: Perhaps I am suffering, Minister, from being an ex-banker, but I like my numbers. Would you be able to provide the Committee with some harder metrics, harder numbers, around the success of specific programmes, perhaps in writing?
Mr Thomas: I will certainly look at what information we have got. We can certainly give you details of where the increase in prevalence is scaling off where we have programmes and where we like to think we have made a contribution. I will certainly try and give the Committee that information, Chairman[8].

Q53 Chairman: Thank you for that. At the end of the UNAIDS report they say, in one sense positively, "For the first time ever the world possesses the means to begin to reverse the epidemic". It says: "We know with increasing certainty what disaster awaits if the response to AIDS continues to be inadequate. We also know how to strengthen that response in a way that will save millions of lives and billions of dollars". Presumably that is what has motivated the international community in a number of very positive declarations to make the commitments that they have for 2010 and 2015. The only scary bit about all of that is that 2010 is three or four years away, the commitment to that particular point on women is for 2010 and we have not met the "three-by-five" targets. In all seriousness, as things stand at the moment what chance do we have of meeting those targets? What do you think both DFID and the UK as part of the international community would need to do, given the big commitment, to raise even more the determination to achieve these targets? The reason we are having this session and making it an annual session is that we feel they are pretty tough targets and unless you monitor them pretty continuously they are not going to be met.
Mr Thomas: They are ambitious targets but I think they are achievable. If they are going to be achieved then donor nations need to follow through, for example, on commitments that were made in Gleneagles in terms of making extra resources available for development and for Africa in particular. Since that initial declaration in Gleneagles around universal access we have taken forward with UNAIDS through the Global Steering Committee process the effort to get in each country national plans that are costed with clear targets so that each country has their own strategy for making sure that everybody who needs access to treatment and, indeed, also to prevention and care can get them. Once those national plans are in place then the international community needs to get behind those plans and make resources available. Within that I think I have described already, Chairman, some of the particular challenges that we face. In many parts of sub-Saharan Africa, for example, health workers, and a shortage of health workers, is one of the key issues to getting access to anti-retrovirals sorted. I would point you to the encouraging statistics that I did give about the way in which there has been a very significant increase in the numbers who have got access to anti-retroviral treatment in the two years between 2003 and 2005, albeit I accept that there is a long way to go.

Q54 Mr Davies: If I could just take you up on that. You quoted these figures in terms of percentage increases but, of course, they are percentage increases from a very low base. I think it might be more helpful if you gave us the actual numbers. Could you just do that?
Mr Thomas: Sure. In sub-Saharan Africa the numbers on treatment increased from 100,000 to 810,000 from 2003 to 2005 and about 1.3 million people were receiving anti-retrovirals in lower and middle income countries by December last year.

Q55 Mr Davies: That is what proportion of those who are HIV positive or estimated to be HIV positive?
Mr Thomas: I would estimate it is just under 25%. The last estimate I saw was that about six million people in developing countries are in need of access

[8] Ev 30

to anti-retrovirals. I will check whether that statistic is broadly right but that is in the right ball park.[9]

Q56 Chairman: The reason why we, and you, are concentrating on these marginalised groups is all of the evidence is they are the drivers of the epidemic so you want to ensure that you are not just increasing the treatment but containing the epidemic otherwise you are chasing a moving target and from the reports we have at the moment it looks like we are holding our own but we are not turning the corner. That is the impression one gets. Last year under the British Presidency there was an EU Declaration made on World AIDS Day, do you anticipate, and is the British Government seeking to encourage, a similar declaration by the EU on that?

Mr Thomas: I think the EU has made its declaration and we are now seeking, with other European donors, to work on the implementation of that declaration through our programmes in-country. We used that declaration to get a united European position in the run-up to the UN General Assembly Special Session in June 2005. I do not think we need another declaration as such, we just need to go ahead and continue implementing that declaration, and that is what we are seeking to do.[10]

[9] The witness has confirmed that this is accurate.

[10] Witness has since provided the following clarification, "Since attending the hearing I understand the Finnish Presidency has drafted a statement that will be released on World Aids Day". Also see supplementary memorandum submitted by witness, Ev 29

Q57 Chairman: It is our intention, which is why we have been pushed to fit this in the timetable, to get this evidence and our report published to coincide with International AIDS Day and it is our continuing intention as a Committee to monitor this situation. As I said at the outset, all the evidence tells us that if we do not deal with the HIV/AIDS epidemic then many of the other MDGs and development objectives will be undermined. That is why we regard it as sufficiently important. It is not just in deference to Jeremy Hunt who, I think it is fair to say, single-mindedly took that issue up and persuaded both the Committee and the Government, and through them the international community, that it was desirable because the targets are tough and if you do not monitor them annually you are not going to meet them. Thank you for coming in and giving us this evidence. In spite of some of the differences in the questioning, I think there is a general recognition that DFID does play a lead role nationally and internationally in this which the Committee broadly supports, but given the challenges are tough it is inevitable that you are going to be pushed as to whether you can do more and whether what can be done can be done more effectively. I think that is a constructive engagement and certainly hope that you think so too. Thank you very much indeed.

Mr Thomas: Thank you.

Written evidence

Memorandum submitted by the Department for International Development

Executive Summary

1. The UK Government welcomes the IDC focus on this important subject. Marginalised groups constitute significant proportions of the people living with HIV across the world: in China, sex workers and their clients are estimated to account for about 20% of people living with HIV; in South Africa, 41.4% of prisoners are estimated to be living with HIV; injecting drug use is estimated to account for just under a third of new HIV infections outside sub-Saharan Africa, and yet coverage of HIV prevention for this group is at best 5% (UNAIDS). And emerging epidemics require urgent attention to ensure that they are contained and reversed so as to avoid generalised AIDS epidemics taking hold.

2. Any plans to achieve the goal of Universal Access to HIV prevention packages, treatment, care and support programmes by 2010 will fail unless we ensure that the needs of marginalised groups—including men who have sex with men, injecting drug users, prisoners and commercial sex workers—are met. At the same time, our efforts to tackle emerging epidemics, which usually start with concentrations of HIV prevalence within marginalised groups, require urgent attention, and a strong focus on meeting the needs of marginalised groups.

3. The UK is proud of its record in promoting the rights of marginalised groups. We continue to provide global political leadership on these issues. The UK is the second largest bilateral donor to AIDS, committing £1.5 billion to AIDS work over the period 2005–08. The commitment to Universal Access, made under the UK's G8 Presidency at Gleneagles and endorsed globally at the 2005 World Summit, was taken forward at the United Nations General Assembly High Level Meeting on AIDS, where the UK played a leading role in ensuring that marginalised groups were reflected in negotiations. The UK has helped influence international discussion on the importance of comprehensive prevention strategies, through the EU Statement on *HIV Prevention for an AIDS-free generation*; and has raised the profile of Harm Reduction to meet the needs of injecting drug users, through the UK policy paper on harm reduction, both published on World AIDS Day 2005.

4. The UK AIDS strategy *Taking Action* set out the priority actions required to tackle emerging epidemics and support marginalised and excluded groups. DFID continues to support UNAIDS to provide effective global leadership on AIDS and coordinate the international response. On the ground, DFID country programmes in Africa, Asia, Eastern Europe, the Caribbean and Latin America are supporting countries to meet the needs of marginalised groups through our support to comprehensive AIDS programmes, as well as targeted support to the most vulnerable groups, and we have a long history of tackling emerging epidemics.

5. Yet much remains to be done. Difficult international negotiations during 2006 have highlighted major differences between countries' approaches to tackling vulnerability. The UK remains committed to achieving Universal Access and will continue to work hard to meet the needs of marginalised groups, as the Secretary of State for International Development made clear in his address to the UN General Assembly High Level Meeting on AIDS in June (see paragraph 28).

HIV and AIDS: Marginalised Groups and Emerging Epidemics

6. DFID welcomes the IDC's decision to review annually the Government's progress on tackling HIV and AIDS in developing countries. We also welcome the decision to focus in 2006 on marginalised groups and emerging epidemics. These two issues, as the Committee recognises, are fundamentally interconnected. Progress in both areas is vital to moving towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.

7. The Government is proud of the position it has taken in support of marginalised groups and on the need to take effective action now to tackle emerging epidemics. When *Taking Action* (the UK's Strategy for tackling HIV and AIDS in the developing world) was published in July 2004 it led the way in identifying the need for a response to AIDS based on human rights and emphasising that specifically targeting action towards vulnerable groups was a key component of a comprehensive response to AIDS. Since then, DFID has continued to actively support the Joint United Nations Programme on HIV/AIDS (UNAIDS) and international partners to pursue and adopt new and bold policies—especially in the area of HIV prevention. This includes the promotion of innovative and evidence-based harm reduction measures such as needle and syringe programmes, safe injecting facilities and substitution therapies to help ensure that injecting drug users have access to support services, and harmonised approaches to AIDS programming.

8. The UK strategy, *Taking Action*, has a particular focus on groups facing social, cultural and financial barriers as well as stigma and discrimination, noting, for example:

> "Women (particularly young and illiterate women) refugees, sex workers, men who have sex with men and drug users all face social, cultural and economic barriers as well as stigma and discrimination which prevent them from accessing health and other services. People in these groups are also less likely to be able to express their particular needs to the institutions that provide services. Where, for example, sex work is driven underground, women who earn a living through prostitution are unlikely to be able to access the specific services that would enable them to protect themselves from HIV. Likewise, where homosexual activity is illegal, it is virtually impossible for programmes to specifically focus on the needs of men who have sex with men"

9. In many places throughout the world, sex between men, sex work and injecting drug use are illegal, heavily stigmatized and sometimes officially denied. These behaviours also make people more vulnerable to HIV infection. Migrants and prisoners are also routinely stigmatised, and their perceived low status worsens further when they are associated with HIV and regarded as a threat to public health. They may also suffer additional discrimination resulting from this association. All people living with HIV are often assumed to belong to one or other of these excluded groups and this misconception may further intensify discrimination and stigma.

10. As a result of stigma, vulnerable or marginalised groups are often denied or by-passed by HIV prevention, treatment, care and support services, while fear of stigma and discrimination discourages many people from seeking these services. In this memo we will focus principally on four groups that are of particular concern, given that the resources delivered to them are not proportional to their HIV prevalence or risk of infection. These groups are: sex workers, males who have sex with males, injecting drug users and prisoners. *Taking Action* also focuses on other groups that are vulnerable either due to their risk of infection or because of the impact of epidemic on them, including women, young people, migrants, people with disabilities, children and older people affected by AIDS. Whilst these latter groups are of great importance, we have limited our focus in this paper to those groups highlighted by the IDC and especially linked to emerging epidemics. While work with marginalised groups is not confined to emerging epidemics, the links are so strong that we have addressed both together in this memorandum rather than separating out our response in emerging epidemics.

Context: Emerging Epidemics

11. The need to work closely with marginalised groups is especially pronounced in emerging epidemics. Several epidemics in Asia are increasing, particularly in China and Vietnam. There are also alarming signs that other countries—including Pakistan and Indonesia—could be on the verge of serious epidemics. Only a handful of countries in Asia are making serious enough efforts to introduce programmes focusing on injecting drug use, commercial sex and sex between males—behaviours driving the epidemics. The same applies in Eastern Europe and Central Asia, where the number of people living with HIV rose in 2005, and in Latin America, where growing numbers of women, especially those living in poverty, are being affected

12. National HIV infection levels in Asia are low compared with some other continents, notably Africa. However, the populations of many Asian nations are so large that even low national HIV prevalence means large numbers of people are living with HIV. Latest estimates show some 8.3 million people (two million of whom are adult women) were living with HIV in 2005—up from 7.6 million in 2003. India has the largest number of people with HIV of any country in the world. Despite the fact that less than 1% of adults are infected, and recent evidence that prevention programmes in some states in India are helping reduce new infections, latest estimates show that two-thirds of Asia's cases of HIV are in India. In Vietnam HIV has spread to all 59 provinces and all cities with approximately 260,000 people living with HIV in 2005, more than double the number in 2000. In Indonesia, although national HIV prevalence remains very low at 0.01%, rapidly expanding AIDS epidemics are being recorded amongst sex workers and injecting drug users in Jakarta. Similarly in Bangladesh HIV infection levels in injecting drug users increased from 1.7% to 4.9% between 2000–01 and 2004–05.

13. The epidemics in Eastern Europe and Central Asia also continue to grow and are affecting ever-larger parts of societies in this region. The number of people living with HIV in this region reached an estimated 1.5 million in 2005—an increase of almost 20-fold in less than 10 years. AIDS claimed almost twice as many lives in 2005 as in 2003, causing the death of an estimated 53,000 adults and children. The overwhelming majority of people living with HIV in this region are young; 75% of reported HIV infections between 2000 and 2004 were in people younger than 30 years (in Western Europe, the corresponding figure was 33%). The patterns of the epidemics are changing in several countries, with sexually transmitted HIV cases comprising a growing share of new diagnoses. In 2004, 30% or more of all new reported HIV infections in Kazakhstan and Ukraine, and 45% or more in Belarus and the Republic of Moldova, were due to unprotected sex. Increasing numbers of women are being affected, many of them acquiring HIV from male partners who became infected when injecting drugs. The bulk of people living with HIV in this region are in two countries: the Russian Federation and Ukraine. Ukraine's epidemic continues to grow, with more new HIV diagnoses occurring each year, while the Russian Federation has the biggest AIDS epidemic in all of Europe. Both epidemics have matured to the point where they constitute massive prevention, treatment and care

challenges. HIV has consolidated its presence in every part of the former Soviet Union, with the exception of Turkmenistan (where little information is available on the HIV epidemic). Several Central Asian and Caucasian republics are experiencing the early stages of epidemics, while quite high levels of risky behaviour in south-eastern Europe suggest that HIV could strengthen its presence there unless prevention efforts are stepped up.

14. The number of people living with HIV in Latin America has not risen since 2003 and remains 1.6 million. In 2005, approximately 59,000 people died of AIDS, and 200,000 were newly infected. Primarily due to their large populations, the South American countries of Argentina, Brazil and Colombia are home to the biggest epidemics in this region. Brazil alone accounts for more than one third of the estimated 1.6 million people living with HIV in Latin America. The highest HIV prevalence, however, is found in the smaller countries of Belize, Guatemala and Honduras—where, by the end of 2003, approximately 1% of adults or more were infected with HIV.

Context: Marginalised Groups

15. Responding to the needs of marginalised groups is not only important in itself, it is often key to halting emerging epidemics, which usually start with concentrations of HIV prevalence in certain groups. These concentrated epidemics are perpetuated through sexual and needle sharing networks within the vulnerable group, but can then spread beyond these contained groups to the wider population. Once HIV moves beyond marginalised groups, countries may face a "mixed", "generalised" and ultimately "hyper-" epidemic where HIV can spread exponentially as can be seen in many Southern African countries. In settings where injecting drug users are closely networked with the general population (eg through sex work), this epidemic growth can be explosive.

16. There are thus both human rights and public health rationales for countries facing emerging epidemics to take immediate action to reduce vulnerability to HIV in marginalised groups. To do this, marginalised groups must be explicitly considered and targeted, as without this focus they are unlikely to access services. Reaching these groups is vital to halting emerging epidemics; it is also their human right to receive the AIDS services they need.

17. In the 2006 Report on the Global AIDS epidemic, half of the countries canvassed acknowledged the existence of policies that interfere with the human rights of vulnerable groups to AIDS services. These include laws criminalizing consensual sex between males or prohibiting condom and needle access for prisoners.

18. Amongst the marginalised groups sex between men is one of the primary ways in which HIV and other sexually transmitted infections are passed on. One in ten HIV cases worldwide is attributed to injecting drug use. The sex industry is generally illegal, a fact that limits sex workers' access to health and other services which might otherwise serve their health and safety needs. A number of studies have shown HIV prevalence is higher in prison than in the broader community with the highest prevalence in South Africa.[1] There, estimates of people living with HIV or AIDS in the penal system are as high as 41.4%.

19. Ironically, the people most affected by AIDS or most at risk of HIV are often neglected by governments and donors alike. So while sex between men is known to place people at higher risk, a recent Swedish study reports that same-sex sex remains criminalised in approximately 70 countries.[2] And laws in at least six countries allow for the death penalty in cases of consenting, adult homosexual acts. Other countries provide for severe punishments, including lifetime imprisonment, forced labour, and public whippings (UNAIDS). In 2002, in 13 Latin American countries, men who have sex with men received disproportionately less funds from national HIV prevention programmes than other groups, given the prevalence of HIV among men who have sex with men.

20. UNAIDS estimates suggest that HIV prevention services are reaching just 36% of sex workers and 9% of men who have sex with men and of approximately 13 million global injecting drug users coverage of HIV prevention is at best 5%. While disaggregated data remains patchy, marginalised groups are also less likely to access formal health services for care and treatment.[3] In prison settings, the availability of appropriate HIV prevention measures, testing, care and treatment is overall extremely low. Where treatment is provided, there have been reports of many prisoners defaulting after their release due to not being able to integrate back into general health services. At best these groups are ignored. At worst enforcement of the "war on drugs" or anti-prostitution or anti-sodomy legislation can force these people underground and into even more risky behaviour, such as sharing syringes.

21. The impact of AIDS has largely been managed by families and communities providing care and support for those living with AIDS. However, people from marginalised groups are often rejected by their families and communities, further isolating them from circles of support. Government and civil society

[1] Dolan *et al* 2004.

[2] I SIDA (2005), *LGBTI issues in the world: A Study on Swedish policy and administration of Lesbian, Gay, Bisexual Transgender and Intersex issues in international development cooperation.* Stockholm: Government Offices of Sweden.

[3] UNAIDS 2006 Report on the Global Epidemic.

assistance has frequently been *ad hoc,* incoherent and fragmented, with the funding available not flowing effectively to community level for many groups. Marginalised groups have been particularly difficult to reach.

22. The international community made important commitments in 2005 and 2006 to achieving universal access to comprehensive HIV prevention, treatment, care and support services. The challenge now is to deliver on these commitments—and not just to the general population but also to those groups that are hard to reach and especially vulnerable.

What Needs to be Done?

23. The international response to HIV has accelerated markedly during recent years. There is now significant political commitment to tackle the epidemic. But to reach marginalised groups and to arrest the development of emerging epidemics, there are uncomfortable realities that need to be faced. There is enough evidence of what works, yet to make things happen norms and behaviours that lead to the exclusion and stigmatisation of certain groups must be confronted. Social change is essential to balance gender relations, and to end the tolerance of AIDS related stigma and gender violence; these are at the very roots of the epidemic.

24. Progress cannot be made without open discussions about sex, sexuality and drugs, and a proper recognition of the range of choices that people make or are forced into. The voices of people living with HIV and AIDS and marginalised groups are essential to guide governments and NGOs in providing the right services so that people can protect themselves. In many places there is a lack of demand for, and uptake of, services provided. Effective community mobilisation of people with HIV and marginalised groups can support focused activities—such as treatment literacy campaigns—and reduce the stigma associated with accessing services.

DFID: Taking Action to Support the International Response

Universal Access

25. The commitment to get as close as possible to universal access to HIV treatment by 2010, made under the UK's G8 Presidency at Gleneagles, was endorsed by the international community at the 2005 World Summit. And the UK has been prominent in helping to ensure that global efforts to turn this commitment into action meet the needs of marginalised groups.

26. In the first quarter of 2006 the UK co-chaired, with UNAIDS, the Global Steering Committee on Scaling Up Towards Universal Access. This process brought together the conclusions of over 100 national and seven regional consultations on how to achieve Universal Access, and made a series of recommendations to UNAIDS as priorities for action to achieve Universal Access. These were presented to the UN Secretary General, prior to the UN General Assembly (UNGA) High Level Meeting on HIV/AIDS in June. The UK also co-chaired, with UNICEF, in February 2006, the Global Partners Forum on Children Affected by AIDS. This Forum met to discuss and articulate the priorities for action to ensure the needs of children affected by AIDS are reflected in national responses and play a central role in efforts to scale up towards Universal Access. The Forum's conclusions also fed into the recommendations made to the UN.

27. The UK played a leading role in ensuring that the UNGA High Level Meeting agreed a Political Declaration that set out the priorities for action to achieve Universal Access. The Declaration that was adopted broadened the international community's commitment to achieving by 2010 not just universal access to treatment, but to comprehensive HIV prevention programmes, treatment, care and support. The UK worked hard to ensure that language relevant to marginalised groups was included in the Declaration, including interventions to meet the needs of injecting drug users such as the provision of sterile injecting equipment and male and female condoms (paras 22 and 26). The Declaration also commits to tackling stigma and discrimination, and to involve civil society, vulnerable groups and people with HIV and AIDS in the response.

28. The negotiations were difficult, with strong opposition from other governments who wished to remove all references to "vulnerable groups". The strength of this opposition meant that UK efforts to spell out those vulnerable groups—to include injecting drug users, men who have sex with men, commercial sex workers, prisoners—were rejected, leading to intense criticism from civil society. The Secretary of State, Rt Hon Hilary Benn MP, echoed their concerns in his address to the UN General Assembly:

> "We need to recognise that tackling AIDS is not only about money. It's also about culture and social attitudes. It's about recognising that while treatment is the key to keeping alive people living with AIDS today, prevention is the key to achieving an AIDS-free generation tomorrow. It's about being honest about what the problem is and about telling the truth about what works. I wish we could have been a bit more frank in our Declaration about telling the truth: That some groups—like sex workers, drug users and men who have sex with men—are more at risk. That some young women—from choice or necessity—exchange sex for money or food. That stigma, discrimination and the unequal position of women and girls in societies make it more difficult to fight this disease. That accurate information, access to sexual and reproductive health and rights, and upholding

human rights all matter in this fight. That condoms protect people from HIV. That clean needles stop injecting drug users from passing on HIV. That abstinence is fine for those who are able to abstain, but that human beings like to have sex and they should not die because they do have sex."

29. The Declaration did include important commitments to make additional resources available (in view of UNAIDS' estimate that by 2010 $20–23 billion will be needed each year to rapidly scale up AIDS responses); and to ensure that costed, inclusive, sustainable, credible and evidence-based national AIDS plans are funded and implemented. There was also provision to monitor progress against these commitments through setting ambitious national targets, including interim targets for 2008, for getting close to Universal Access by 2010. DFID is working with UNAIDS and many governments to support their efforts to set these targets by the end of 2006, and to ensure these targets reflect the needs of marginalised groups.

Prevention

30. During 2006 the UK has contributed to achieving increasing international recognition on the importance of a comprehensive approach to HIV prevention. As the IDC is aware the UK fought hard for UNAIDS to agree a progressive policy on Intensifying HIV Prevention in May 2005. This was in the face of substantial opposition from some countries unwilling to see reference to the full range of prevention approaches for which there is substantial evidence and research proving their effectiveness (eg needle and syringe programmes) essential to meeting the needs of marginalised groups. The UK is now working closely with UNAIDS to ensure that this progressive policy is translated into effective guidelines that can mobilise effective country responses, and to address some of the outstanding debates, such as on the role of behaviour change in preventing sexual transmission of HIV.

31. In December 2005, under the leadership of the UK Presidency, the EU published a common position on HIV prevention—"The EU Statement on HIV Prevention for an AIDS Free Generation". This clearly signifies that the EU is ready to support country governments to enable all partners, including civil society, to develop and implement coordinated and effective HIV prevention programmes, and stresses the importance of evidence-based prevention for marginalised groups.

32. The EU Statement advises that effective programming includes: universal access to sexual and reproductive health information and services for all people including young people; provision of harm reduction programmes and services (see para 35) to meet the needs of injecting drug users; reliable access to essential sexual and reproductive health supplies including male and female condoms and clean injection equipment; access for all children to a secure education that includes life skills and sexuality education;[4] integration of HIV prevention interventions including voluntary counselling and testing; action to confront and address gender-based violence; investment in the development of new HIV prevention methods such as microbicides and vaccines; promoting the adoption of good workplace information and practice.

33. This statement has provided a strong political signal about the importance of prevention, and of a comprehensive approach to prevention—which was subsequently endorsed by the international community at the UNGA High Level Meeting on HIV/AIDS. We continue to use this statement to press for comprehensive prevention services, especially for marginalised groups.

Harm reduction

34. On World AIDS Day 2005, the UK Government published its first policy position paper on Harm Reduction. Harm Reduction strategies aim to reduce the health and social consequences of drug injecting. The UK policy paper, agreed across Whitehall, sets out the case for implementing a comprehensive approach to harm reduction—including drug substitution therapy, sterile needle and syringe access and disposal programmes, outreach programmes, primary healthcare, prevention of sexual transmission among drug users, provision of education and advice about HIV, and access to affordable clinical and home-based care.

35. This document has been well-received across the world, and has proved useful to proponents of harm reduction in setting out the case for tackling HIV amongst injecting drug users. DFID is currently working with other government departments (notably the FCO and Home Office) and through the Informal Cross-Whitehall Coherence Group on tackling HIV and AIDS in the Developing World to look at how to implement this policy. Future efforts will include working more closely with the UN Office on Drugs and Crime (UNODC—a co-sponsor of UNAIDS), which has the international lead on harm reduction efforts.

[4] "Sexuality education" is the preferred term. Others use the term "sex education" but this describes a more limited, less progressive approach. Good sex or sexuality education enables young people to acquire information and form attitudes and beliefs about sex, sexual identity, relationships and intimacy as well as developing the life-skills (eg negotiation, condom use, how to access sources of contraception) necessary to ensure healthy sexual and reproductive lives. All too often sex education is limited to imparting information about genital anatomy and basic science knowledge about sex and reproduction; and ignoring the cultural and social attitudes that inform values and beliefs.

UK funding

36. The UK is the second largest bilateral donor to AIDS programmes and has committed to spend at least £1.5 billion on AIDS work over the period 2005–08. The UK is helping to deliver access to prevention, treatment, care and support services to marginalised groups through our support to comprehensive AIDS programmes as well as targeted support to the most marginalised groups. UK funding is directed through bilateral programmes in key countries, to some research and development programmes, and through multilateral and international bodies.

UNAIDS

37. UNAIDS—which co-ordinates the response of 10 UN agencies—leads the international response to AIDS. UNAIDS has a strong record in supporting marginalised groups and leading efforts to tackle emerging epidemics, including through advocacy, dissemination of strategic information, policy support and guidance. UNAIDS has published many important documents relevant to these groups including a Policy Brief on men who have sex with men, supporting research on injecting drug users; and publishing best practice studies on injecting drug users and sex workers in Eastern Europe, and men who have sex with men in Asia and the Pacific. UNAIDS also supports the development of networks of people with HIV and AIDS in countries and at global level, as well as supporting responses in emerging epidemics. UNAIDS and its co-sponsor WHO are collaborating on a programme (£6.6 million over three years) to support tracking emerging epidemics and epidemics among marginalised groups with specialized surveillance and epidemiological modelling. WHO is developing a compendium of evidence on the success of various interventions to prevent HIV (including activities targeted at marginalized groups). The United Nations Office of Drugs and Crime (UNODC) has issued a framework on HIV prevention in prisons and care for female IDUs.

38. To support UNAIDS work, including with marginalised groups, DFID is providing £36 million core funding to UNAIDS over four years (2004–08). An additional £8 million has been given this year to recognise the high level of performance and to support their work implementing the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT). This year one of the key activities related to the GTT has been the establishment of a clearer division of labour on responsibilities for HIV prevention among UNAIDS co-sponsors.

39. DFID supports UNAIDS to: provide effective global leadership on AIDS and enable its Secretariat and country coordinators to fulfil their coordination and catalytic role within the UN family and at country level. This is essential to UNAIDS role in implementing the "Three Ones" and GTT recommendations at country level, including brokering partnerships outside the UN. To ensure strong systems are in place to monitor the impact of HIV and AIDS and responses to the pandemic, DFID is supporting the Programme Coordinating Board and the Unified Budget and Workplan to provide an effective governance structure for management of UNAIDS' joint programme.

Marginalised groups and emergency situations

40. DFID recognises that populations destabilised by armed conflict, humanitarian emergencies and natural disasters (including both refugees and internally displaced people), and particularly women and children in such situations, are at increased risk of exposure to HIV.

41. DFID therefore funds a UN System-Wide Work Programme for scaling up AIDS services for populations of humanitarian concern. This programme (£6.6 million over three years) is co-ordinated by the World Health Organisation and UNAIDS. Partner agencies include other UNAIDS co-sponsors, in particular WFP, UNICEF, UNDP and UNHCR. The programme aims to strengthen the UN humanitarian response to provide better help to vulnerable populations in acute and prolonged crisis and disaster situations.

42. This programme will implement national strategies which incorporate different AIDS elements into programmes or actions that respond to emergency situations, and where appropriate AIDS components will also be factored into international assistance programmes. Specific importance is attached to identifying gender-based factors, including sexual violence, which heighten the vulnerability of girls and women, and to addressing these through the appropriate prevention, care and support interventions.

Global Fund to fight AIDS, TB and Malaria

43. The UK has been an important supporter of the Global Fund since it was established in 2001. The UK sits on the Board of the Global Fund (in a constituency with Australia) and has committed £359 million to the Fund over the period 2002–08. This includes £100 million for 2006 and a pledge of £100 million for 2007 subject to performance.

44. The UK's contributions have helped deliver funds to support marginalised groups, for example through a US$ 4 million Global Fund grant to the Russian Harm Reduction Network to scale up access to HIV prevention and treatment in the Russian Federation, and US$ 31 million over five years to Indonesia's HIV/AIDS Comprehensive Care programme. The Russia programme aims to strengthen HIV services for injecting drug users by; significantly increasing the coverage and quality of HIV services for drug users (including those who sell sex and people with HIV) in 33 cities; increasing the demand for HIV prevention services; and providing care and support for people with HIV and AIDS through community mobilisation and capacity building at community level. The Indonesian programme aims to reduce the number of HIV infections among female sex workers and transvestites through increased awareness of risky behaviours, condom use promotion and care and support services. The programme aims to reach over 150,000 female sex workers and transvestites through quality outreach programs managed by 150 local organizations.

Community organisations

45. Through Partnership Programme Agreements (PPAs) DFID supports 26 NGOs, 18 of which identify AIDS-related activities as part of the outcomes or success criteria they are working towards. Of particular importance is DFID's support to the International HIV/AIDS Alliance which this year will receive £3.75 million—a 36% increase on the previous year. The Alliance focuses on action to address AIDS in marginalised groups and emerging epidemics, and the DFID PPA focuses on four strategic outcomes:

— Improved coverage of effective community focused action on HIV and AIDS.

— Strengthened leadership and capacity of civil society to effectively participate in national responses to AIDS.

— Improved national and international policy and financial environment for more effective civil society responses to AIDS.

— An Alliance of national linking organisations working effectively together.

46. In addition to more general NGOs, organisations of people living with HIV and AIDS have a particular role in representing the interests of people with HIV and giving them a voice wherever policies and decisions are being made that affect their lives. Strong movements of people living with HIV and AIDS can hold countries and donors accountable. In Brazil, South Africa, Thailand and Uganda, for example, people living with HIV and AIDS have been able to put AIDS on the agenda and (in particular) lobby for treatment. They have also demonstrated an ability to address the stigma related to AIDS and reach the "hot spots" of an epidemic as it emerges.

47. This year, DFID has committed £1.75 million (over three years) to strengthen global networks of people living with HIV and AIDS and to build their and their organisations' capacity to contribute to the formulation, development and implementation of effective AIDS policies and programmes. This funding is being provided to the following organisations:

— £1 million to the International Treatment Preparedness Coalition (ITPC). ITPC is a global network that brings a high level of technical expertise on HIV treatment and care, with a particular strength in developing treatment literacy programmes. DFID's funding will help the network strengthen its communication and dissemination of this expertise at its grass roots level.

— £375,000 to the Global Networks of People living with HIV and AIDS (GNP+). GNP+ has played a strong international advocacy role and the funding will help strengthen their existing networks and increase the involvement of people living with HIV and AIDS in the development and implementation of policy.

— £375,000 to the UK based International Community of Women living with HIV/AIDS (ICW). ICW is the only international network run by and for HIV positive women. This funding will help ICW maintain contact with women living with HIV all over the world, share life-saving information about their health and rights, influence policies and attitudes and dispel myths about women and AIDS.

DFID Taking Action on the Ground

48. As already noted, action to support marginalised groups and to halt emerging epidemics, is essential to make real progress in scaling up towards Universal Access. DFID supports countries to develop and commit to strong national AIDS plans. But marginalised and excluded groups do not necessarily benefit from broader national programmes because of social, cultural and economic barriers and stigma and discrimination preventing them from accessing services. And existing national laws and regulations designed to protect people living with HIV from discrimination are often not fully implemented or enforced. DFID supports approximately 100 projects and programmes that address AIDS-related stigma and discrimination throughout the world. These programmes include activities to foster respect and understanding towards people living with HIV and AIDS, men who have sex with men, sex workers and injecting drug users. They also support these groups to take a stand against discrimination and fight for their rights.

Africa

49. In many of the generalised epidemics in Africa, DFID is working with marginalised groups. In Ethiopia, Ghana, Kenya, Malawi, Mozambique and Southern African Development Community, DFID supports programmes that work towards legal and policy frameworks protective of human rights of people living with HIV and AIDS and vulnerable groups. In Kenya, for example, DFID funding enabled the national network of people living with HIV and AIDS and the National AIDS Commission to hire constitutional lawyers to challenge new legislation on the criminalisation of HIV transmission. Other programmes focus on legal education and rights awareness of people living with HIV and AIDS (Malawi), women with HIV and children affected by AIDS (Uganda), sex workers (Togo) and young people (Niger and Rwanda).

50. In countries where Governments have failed to adopt effective national programmes, DFID works with international and national non-governmental organisations to develop and implement AIDS strategies. For example **DFID Zimbabwe** has committed £12.6 million to a four-year programme being implemented by Population Services International (PSI)-Zimbabwe, and co-funded by USAID to raise awareness of AIDS and striving to reduce social stigma. The mass-media campaign (funded by DFID Zimbabwe) directed at reducing prejudices and discrimination against people living with HIV and AIDS, won the 2005 Global Media Award.

51. **DFID Kenya's** HIV and AIDS Prevention and Care Project (HAPAC) supports the National AIDS Control Council as well as a network of community based organisations working with injecting drug users. DFID Kenya is also working with UNODC to support the Kenyan Prison Service strengthen service provision for those with HIV and TB. A policy seminar on Prisons and Prevention of HIV is planned to be held in Kenya's largest prison (Kodiaga Prison in Nyanza).

52. **DFID Nigeria's** programme Promoting Sexual and Reproductive Health for HIV Reduction has some focus on the needs of sex workers, males who have sex with males and injecting drug users. An assessment of high risk areas in Lagos State has been undertaken and trained community-based workers visit these areas to provide condoms and facilitate discussions on AIDS with commercial sex workers.

Asia

53. In Asia, DFID supports several programmes on legal reform and the inclusion of the rights of vulnerable groups and women in policies and laws. The programmes concentrate on women's rights (Bangladesh, China, Pakistan), rights of injecting drug users and sex workers (China, Vietnam), trafficking of children and women into prostitution (China, Nepal), and empowerment of migrants (Asia regional).

54. **DFID India** provides £123 million to support the National AIDS Control Programme of the Government of India, focusing on eight states. A key plank of the national response to HIV is to implement focussed prevention programmes with high risk groups—known as Targeted Interventions. In India these groups are primarily commercial sex workers, males having sex with males and injecting drug users. By definition they are marginalised because their behaviour is illegal. Both financial and technical assistance is provided to these programmes.

55. To complement the Government of India's programme DFID India also launched a Challenge Fund in 2005 to support innovative pilot interventions with marginalised groups, thus allowing civil society to respond to emerging epidemics and challenges. It is intended that these interventions can inform future policy and programming. DFID also supports efforts to reduce stigma and discrimination.

56. DFID is also helping to finance an Asia-Pacific regional consultation on male sexual health and HIV. The meeting will focus on the risks faced by males who have sex with males and cultural vulnerabilities and the risks of not addressing them with adequate and appropriate HIV prevention, treatment, care and support interventions, while highlighting the need for responsibility. DFID is also supporting a number of regional activities to scale up the HIV and AIDS response to marginalised groups, including the NAZ Foundation (an NGO based in India) for work with males who have sex with males in India, Pakistan, Bangladesh and Nepal and some work in South East Asia; the WHO Western Pacific Regional Office in Manila for harm reduction work in Vietnam and China; and to Family Health International for HIV services directed at Nepali migrant workers to India, for services in their home communities in Nepal, and in destination communities in India. Funding NGOs like the NAZ Foundation reinforces groups and individuals struggling to implement evidence-based interventions such as needle and syringe exchange which may be very different from the usual approaches in certain countries.

57. DFID India is also supporting disability-friendly AIDS programming by funding research looking at ways of reaching disabled people with HIV prevention messages and other services. The research includes both mental and physical disabilities and is working with representative organisations as well individuals.

58. HIV infection rates are expected to increase dramatically in **China** with a growing number of drug users and sex workers and increasing internal migration. Clusters of high HIV prevalence exist within certain geographic areas and specific sub-groups (notably injecting drug users and sex workers), particularly among the remote, mountainous regions of the south west that are home to 85% of China's poor. In recent years the Government of China has launched new policies on AIDS and introduced new legislation on prevention,

treatment, care and support including anti-stigma and discrimination. China's domestic funding for tackling AIDS has increased from £32 million in 2003 to £72 million in 2005. This is however still short of the estimated annual need of £220–400 million for an effective response.

59. DFID China has supported the Government of China's AIDS efforts since 2000. Initially DFID committed £20 million to a Ministry of Health project in Yunnan and Sichuan provinces to pilot new prevention work with injecting drug users, sex workers and men who have sex with men. This was the first project in China to routinely and extensively develop locally appropriate interventions for injecting drug users, sex workers, and men who have sex with men. It introduced condom promotion, needle exchange and methadone substitution using participatory peer education processes. Achievements included: increased consistent condom use between female sex workers and clients; reduced needle sharing; reduced discrimination by health providers.

60. This DFID-supported project demonstrated that it is possible to implement affordable HIV prevention interventions in China that are effective in changing high risk behaviours in communities of female sex workers and their clients. It has made a significant contribution to the development and implementation of China's own policy at national, provincial and county level to ensure that AIDS programmes focused on marginalised, high risk groups.

61. Building on the success of the pilot programmes DFID committed a further £30 million in August 2006 to help the Government of China's national AIDS programme contain the number of people living with HIV and AIDS to 1.5 million by 2010. The new project will build on the success of the pilot programmes project and expand coverage to five new provinces (Xinjiang, Guangxi, Guizhou, Hunan and Jiangxi).

62. The new funding is part of a £92 million programme also supported by the Global Fund to fight AIDS, TB and Malaria. The programme focuses on seven provinces which account for 89.5% of HIV and AIDS cases among drug users in China. The programme will support a range of activities, including the development of local plans on AIDS linked to the local government's economic development plan for 50 counties, with a total population of 28 million; contracting 70 civil society organizations to implement activities in target counties; 45,900 female sex workers and their clients receiving intervention services; 159,700 injecting drug users receiving prevention services; 208,660 people with high risk behaviours receiving voluntary counselling and testing services; and 6,000 people with advanced HIV infection receiving ARV combination therapy.

63. In **Cambodia**, adult HIV prevalence has dropped from 3% in 1997 to 1.9% in 2003. The promotion, advertising and distribution of condoms to sex workers and their clients (the main drivers of the epidemic) through the 100% Condom Use Programme is recognised as being a critical component of this success. DFID has supported condom social marketing in Cambodia since 1994 with total funding to date of £12.9 million. About 20 million of the *Number One* brand condoms are sold annually with a significant proportion being used by sex workers and their clients; 95% of sex workers report consistent use of condoms with clients. About 160 million condoms have been sold to date. Other key target groups for condom use are: the military, police, moto-taxi drivers and "indirect" sex workers (who often work in karaoke bars etc).

64. In **Bangladesh**, societal attitudes result in extremely negative perceptions regarding sex work. Sex workers are caught in a vicious cycle, rejected by their families and society, denied access to basic services, and subjected to varied forms of discrimination, stigmatisation, sexual and physical abuse, and incarceration, while their children are treated as social outcasts. The law generally ignores violence against sex workers, and most cases are unreported because of the ambivalent position of the law and the attitudes of the law enforcers. Police themselves are often guilty of the worst offences, and sometimes demand sexual favours in return for protection. Due to their social marginalisation, lack of access to health services, and the inability to negotiate safe sex with clients, sex workers are extremely vulnerable to HIV infection.

65. In Bangladesh DFID supports an outreach programme that empowers sex workers and their children to demand their rights for basic services and raise awareness of the discrimination and abuse they face among civil society, local government, education authorities, and service providers.

66. **Burma** has one of the most serious epidemics in South-East Asia. Although this is now a generalised epidemic (national adult HIV prevalence is 1.3%), marginalised groups (particularly sex workers and injecting drug users) are most affected. Over one in three injecting drug users and commercial sex workers are living with HIV. And it is estimated that 68% of transmission is due to sexual transmission—with the rest related to injecting drug use. The UN has called for increased programming for the populations most at risk to HIV (especially sex workers, their clients, injecting drug users and men who have sex with men). DFID has recently approved a contribution of £20 million over five years to the multi-donor "Three Diseases Fund"; a major proportion of this fund will be used to implement AIDS activities, with particular attention paid to ensuring that resources are directed to those marginalised and excluded groups most in need of services.

Europe and Central Asia

67. **DFID Belgrade** is providing £1.5 million (April 2003–07) to the Western Balkans HIV Prevention among Vulnerable Populations Initiative. This programme has successfully used demonstration harm reduction projects with civil society to influence policy. A recent independent evaluation acknowledged that investments in harm reduction field activities generated evidence and a range of recommendations for policy change; as a result the Government of Serbia recognised that harm reduction is one of the methods to fight HIV/AIDS and included it as an important part of its national HIV and drug prevention strategy. The programmes outputs also include; capacity strengthening for HIV prevention organisations; transference of expertise and an epidemiological evidence base.

68. **DFID Russia** has supported 30 harm reduction projects providing activities on needle exchange, counselling and education of injecting drug users, distribution of condoms and disinfectants, provision of medical services. In addition DFID Russia is funding the Knowledge for Action Russia project to generate epidemiological and behavioural research data on target groups (injecting drug users, sex workers, young people, etc) in two regions of the Russian Federation which will be used as an evidence to inform regional and national policy development.

69. DFID Russia is now providing £500,000 to support the programme "Co-ordination in Action: implementing the Three Ones principles in combating HIV/AIDS in the Russian Federation" (Jan 2001–March 2007). The purpose of this programme is to facilitate a major change towards a joined up, well co-ordinated national response with a single coordinating authority and one country-level monitoring and evaluation system. This programme has provided indirect support to the national networks of people with HIV and AIDS for national networking, strengthening of internal expert groups within the networks and development of common position documents on harm reduction and universal access.

70. **DFID Ukraine** is implementing a number of projects that target men who have sex with men as a marginalised group. Working with a local Ukrainian Charity, "Health of Nation", DFID Ukraine is supporting a network of community centres for men and providing HIV and STI prevention through outreach work with men-having-sex-with-men in the two biggest cities of Donbas, the main mining and heavy industry area of Ukraine. This programme provides legal education and awareness of rights as well as legal support to men who have sex with men.

71. DFID's approach also focuses on piloting, and assisting in the national implementation of harm reduction interventions including needle and syringe programmes, safe injecting, substitution therapy, social marketing, outreach and peer education through government partners, international and local NGOs.

Caribbean and Latin America

72. In **Latin America**, DFID is working along with GTZ and UNAIDS to develop ways to provide technical support to National AIDS Programmes in the region, through an International Centre for Technical Cooperation on HIV and AIDS, based in Brasilia. There is a strong focus on meeting the needs of vulnerable and marginalised groups. The centre promotes low cost appropriate means of providing technical support, to help the various national programmes to improve implementation and make better use of funds allocated by the Global Fund and other donors.

73. In **Central America**, DFID is providing additional funding to a World Bank programme designed to meet the needs of cross-border migrants. These populations are very vulnerable to HIV and the programme will work to develop innovative approaches to working with these mobile populations.

74. A DFID **Latin America** programme in the Atlantic coastal regions (in Honduras and Nicaragua, Central America) is working to support the needs of selected vulnerable migrant groups, including people living with HIV and AIDS. There is a strong focus on working with young people, ensuring they have access to services and raising their awareness of the links between human rights, HIV and adolescents' rights to gain access to reproductive health services. The programme is part of a larger World Bank initiative in Central America and develops partnerships with various local groups who are working with these hard to reach populations.

75. In **Nicaragua**, a second programme focuses on improving the legislative framework and policy environment for protecting the rights of people living with HIV and AIDS.

76. In **Latin America and Caribbean**, DFID Brazil and DFID Caribbean are jointly sponsoring the first ever Regional Consultation to make Sex Work Safer, working closely with UNAIDS and the innovative Brazil STD/AIDS Programme. The event will take place in Lima, Peru in December 2006 and will be an opportunity to compare the experiences from a wide range of countries and develop ways to lobby for changes in the way services are provided and to encourage legal amendments to promote harm reduction and reduce stigma and discrimination.

77. **DFID Caribbean** is working with the Pan-Caribbean Partnership Against HIV and AIDS to develop a region wide "Champions for Change" programme, in part to tackle extreme stigma and discrimination against men who have sex with men and other marginalised groups. Events for political leaders, music and

cultural icons, and a forum for faith based organisations have been held and a further focus on the role of the electronic and print media is planned for December 2006.

78. DFID also recently announced support of £2.5 million (over three years) for the "Accelerating Private Sector Responses to HIV/AIDS in the Caribbean", a programme being piloted in the tourist resort areas of **Barbados and Jamaica**, one element of which is to address sexual behaviour between men in the tourist industry.

CONCLUSION

79. The UK continues to provide global leadership in the response to AIDS. We have been at the forefront of recent developments which mean that the global response to HIV can realistically talk of meeting the MDG goal to halt and reverse the spread of HIV. Our strategy for tackling HIV and AIDS in the developing world *Taking Action* identifies the importance of ensuring that the needs of marginalised groups are met. It will be impossible to achieve Universal Access without doing so. The UK is working hard to ensure that marginalised groups have access to comprehensive HIV prevention, treatment, care and support services; and are included in both the dialogue around how to provide those services, and the delivery of those services.

80. We will continue to work hard with this objective. We look forward to the results of the independent interim evaluation of *Taking Action*, which will include a working paper specifically focussed on marginalised groups. The findings from this evaluation will inform the UK's action on AIDS following *Taking Action*.

October 2006

Letter to the Chairman of the Committee from Mr Gareth Thomas MP, Parliamentary Under-Secretary of State, Department for International Development

At the International Development Committee Hearing on HIV and AIDS on 16 November you asked whether the Government was seeking to encourage a new EU declaration on HIV and AIDS, for World AIDS Day.

On World AIDS Day 2005, under the leadership of the UK Presidency, the EU made a bold Statement on HIV Prevention for an AIDS-Free Generation. This Statement has had a powerful effect. For example it was key to achieving a common EU position on HIV and AIDS in advance of the United Nations General Assembly High Level Meeting on AIDS in May 2006. It has also been used by EU Member States to help re-invigorate a national focus on HIV prevention, for example in Uganda.

As I said at the hearing I don't believe we need a new EU Declaration on HIV prevention. Since attending the hearing I understand the Finnish Presidency has drafted a statement that will be released on World AIDS Day next month. This is a general statement which will provide an update on the global AIDS situation and will highlight progress made during 2006. UK officials, through formal and informal discussions, have encouraged the Finnish Presidency to focus on areas that require continued advocacy and strengthened support of the EU. As a result of UK engagement we expect the Finnish Statement to highlight the urgent need to address the shortage of sexual and reproductive health supplies such as male and female condoms. We have also suggested that the Finns focus attention on the need to address the stigma and discrimination faced by people vulnerable to and living with AIDS.

We welcome the effort of the Finnish Presidency to renew the EU's commitment to the AIDS response, and appreciate that it builds on the UK Presidency-sponsored Statement on HIV prevention last year. However, the big challenge now is to translate these crucial commitments into action in the most affected countries.

At the hearing I also agreed to provide information on our representations to President Museveni and to send you some statistics to demonstrate the success of specific programmes. This will follow shortly.

November 2006

Further letter to the Chairman of the Committee from Mr Gareth Thomas MP, Parliamentary Under-Secretary of State, Department for International Development

At the International Development Committee Hearing on HIV and AIDS on 16 November, I said I would let the Committee know what representations have been made to President Museveni.

I can confirm that senior DFID officers, including Sir Suma Chakrabarti in January 2005, have met the President and Ugandan Ministers to stress the importance of continuing strong and consistent political leadership around a comprehensive strategy for HIV/AIDS prevention and treatment. Specifically, we have

helped the Director General of the Ugandan AIDS Commission in briefing the President. As a result of this, President Museveni cautioned the Ugandan people not to become complacent to the continuing threat that HIV poses.

At the National Health Assembly in 2005, health development partners implored President Museveni and his Government to do much more to reverse the spread of the disease and mitigate against its impact. At the national launch to "Re-intensify HIV Prevention" on 8 August, presided over by the Vice-President, DFID made a statement (attached*) on behalf of AIDS Development Partners. The Vice-President reaffirmed the Government's commitment to a comprehensive prevention strategy that includes promotion of condoms.

I also said I would provide some statistics on the success of specific DFID programmes. I am attaching these with this letter.

December 2006

Specific DFID Country Programmes

Whenever possible DFID works with national governments and other donors to support country leadership to tackle HIV and AIDS through the "three ones" (one national authority, one strategy and one monitoring framework). A consequence of this is that DFID is often one of a number of donors that jointly fund developing countries' national HIV and AIDS programmes, and it is therefore difficult to attribute a programme's success to DFID alone. However, in the following examples, DFID has had a central role in developing and implementing programmes that have made important contributions to the AIDS response:

Malawi

DFID has committed £100 million to support Malawi's health sector over a period of six years (2005–06 to 2010–11). Out of this, £45 million is allocated for an Essential Health Package which includes the prevention and management of HIV and AIDS, including HIV Testing and Counselling, access to Anti-Retroviral Therapy and other related services.

DFID is the largest donor to Malawi's health sector and has provided significant financial and technical support to the Government of Malawi's response to the HIV and AIDS epidemic. As a result:

- HIV infection levels have stabilised at 12% and in some areas there has been a shallow decline;
- The number of people tested for HIV more than doubled last year alone to 440,000;
- The number of people living with HIV and AIDS started on ART increased from 4,000 (2003) to 70,000 in September 2006;
- Over 1,000 organisations have received funds to implement the HIV and AIDS response, most at the community level;
- Over 350,000 orphans received material support in the form of food, clothes and uniforms. The National AIDS Commission itself funded support to over 285,000. Over 200,000 Orphans and Vulnerable Children (OVCs) received nutritional care, 36,000 received financial support and 64,000 received other forms of care and support;
- By December 2005 there were 239 approved HIV Testing and Counselling sites (compared to 11 in 2004);
- By May 2006 119 sites were offering Prevention from Mother to Child Transmission (PMTCT) out of a potential 617 sites, which is still low but an improvement on last year.

China

DFID China has supported the Government of China's AIDS efforts since 2000. Initially DFID committed £20 million to a Ministry of Health project in Yunan and Sichuan provinces to pilot new prevention work with injecting drug users, sex workers and men who have sex with men. This was the first project in China to routinely and extensively develop locally appropriate interventions for injecting drug users, sex workers, and men who have sex with men. It introduced condom promotion, needle exchange and methadone substitution, using participatory peer education processes. Achievements included:

- 129,000 people were reached by interventions in 83 counties by 2005;
- 4.2 million condoms distributed in 2003–05;
- 1.28 million disposable syringes distributed and 1.14 million needles and syringes reclaimed;
- 57 community groups were established to provide support to people living with HIV and AIDS.

* Not printed.

Burma

DFID has committed £20 million over five years to the multi-donor "Three Diseases Fund"; a major proportion of this fund will be used to implement AIDS activities, with particular attention paid to ensuring that resources are directed to those marginalised and excluded groups most in need of services.

The Fund has supported outreach programmes for Commercial Sex Workers and their clients and the 100% Condom Use Programme. Prevalence rates amongst pregnant women in ante-natal clinics have declined from 1.4% in 2003 to 1.3% in 2005. The following table demonstrates the impact of the funds programmes which are largely attributed to for the fall in HIV prevalence.

Core indicator	*Apr 2004–Mar 2005*	*Apr 2005–Mar 2006*
Number of condoms distributed	32,867,486	42,616,027
Number of clients to STI services	178,391	209,839
Number of STI clients at health care facilities diagnosed, treated and counselled	136,177	154,979
Numbers of needles and syringes distributed to IDUs	43,389	156,009
Number of people with advanced HIV infection receiving ARV therapy	734	2,953
Number of health education sessions on HIV and AIDS conducted	41,468	57,697

Serbia and Montenegro

DFID is providing £1.5 million between 2003 and 2007 to the HIV Prevention among Vulnerable Populations Initiative in Serbia and Montenegro. The programme has initiated, funded and guided the implementation of a cohesive programme of 12 innovative evidence-based HIV prevention demonstration projects targeting vulnerable groups—injecting drug users, sex workers, men who have sex with men, people living with HIV and AIDS, prisoners, sailors, Roma, and internally displaced people in Serbia.

In the two-year implementation process, demonstration projects have:

- Assisted 4,850 clients in total (70,000 contacts), including 960 injecting drug users, 350 sex workers, 830 prisoners, 600 sailors, 2,270 Roma, 50 people living with HIV and AIDS etc.
- Targeted 1,200 clients in the field (outreach), including 550 home visits to people living with HIV and AIDS and injecting drug users.
- Included 350 clients in the methadone substitution treatment.
- Provided 5,300 individual and 700 group counselling and therapy sessions, targeting 8,200 clients.
- Referred 2,800 clients to health and other institutions for further services.
- Organized 180 training events for professionals, outreach workers and volunteers in how to provide targeted AIDS services for vulnerable groups (2,800 participants).
- Distributed 27,000 syringes and 34,000 needles.
- Distributed 55,000 condoms.
- Disseminated 60,000 pieces of promotional material and participated in more then 280 media related activities.

Caribbean

DFID is providing £1.7 million over five years to the Caribbean Epidemiology Centre to support a multi-donor programme to address sexually transmitted infections. An evaluation of the programme showed the following achievements in 21 Caribbean Epidemiology Centre (CAREC) member countries from 2001 to 2005:

- 4,681 CD4 tests conducted for eight countries in 2005, up from 10 tests for two countries in 2001.
- 10 labs with CD4 technology in 2005, up from 0 in 2001.
- nine countries with care and treatment plans in 2005, up from 0 in 2001.
- Seven countries using BCC manual in 2005, up from 0 in 2001.
- 72 research projects completed and 37 partnerships created or improved.

Cambodia

Effective collaboration between Cambodia's government, civil society and development partners has helped reverse the trend of the HIV epidemic among adults from 3% in 1997 to 1.9% in 2003.

Since mid-1995 DFID has provided support to a condom social-marketing programme which has been crucial to improving availability and access to condoms in urban and rural areas. DFID's commitment is £7.1 million from 2001 to 2007. Since 2003 DFID has provided technical and financial support to the national HIV/AIDS programme and a recent external review shows that the DFID-supported programmes have been very successful in helping to reduce vulnerability to HIV and improving care and support to people living with HIV and AIDS. DFID's total commitment to this programme is £15.6 million from 2003 to 2007.

Under the guidance and co-ordination of the National Centre for HIV/AIDS Dermatology and STDs (NCHADS) and the Ministry of Health, and with support from DFID and other development partners, the ARV treatment programme has rapidly expanded as shown in the following table:

	2000–01	*2003*	*2004*	*2005*	*Jan-Sep 2006*
Sites for Voluntary Counselling and Testing (VCT)	12	51	74	109	143
People receiving VCT	10,447	41,060	59,184	152,147 (54% female)	98,756 (55% female)
Adults and children on Anti-Retroviral Treatment (ART)	74	2,230	5,974	12,355 (48% female)	16,379 (as of 30 June 2006) (49% female)
Children on ART	—	—	452	1,071	1,493 (as of 30 June 2006)

December 2006

Memorandum submitted by the International HIV/AIDS Alliance

EXECUTIVE SUMMARY

1. The International HIV/AIDS Alliance has a special interest in HIV, marginalised populations and emerging epidemics with over 12 years experience working with sex workers, gay men and other men who have sex with men, injecting drug users and people with HIV/AIDS in Asia, Africa, Latin America, the Caribbean and Eastern Europe.

2. Global commitments to universal access to HIV treatment, care, support and prevention mark a significant development in global AIDS policy. However early responses to these new commitments by national governments suggest little or no attention to the needs of marginalised populations in national planning for universal access.

3. Our experience in working with marginalised populations demonstrates widespread HIV risk and vulnerability amongst these groups, very low levels of access to basic HIV services, along with widespread violations of human rights. Without a sea change in our approaches to reducing the vulnerability of marginalised populations and addressing human rights violations against these groups, universal access will not be realised.

4. A global HIV services gap exists which sees 95% of injecting drug users, 89% of men who have sex with men, and 84% of sex workers without access to basic HIV services.

5. HIV/AIDS is fuelled by human rights violations and human rights violations exacerbate the impact of AIDS. Very few interventions to address human rights violations against marginalised populations are funded, designed or implemented.

6. Support for AIDS programming from donors must be flexible enough to respond to diversity in the nature of different epidemics. In addition, AIDS programming must be guided by principles of equity and effectiveness so that funding mechanisms do not reinforce existing discriminatory approaches to marginalised populations. Donors must guard against avoiding funding work that is politically sensitive or ideologically bound.

7. HIV prevention approaches must be integrated into broader development strategies to address the causes and consequences of social and economic deprivation, which in turn leads to HIV vulnerability.

8. The UK Government's leadership role in international policy fora to speak about and champion the rights of marginalised populations is applauded by the Alliance. This support can be expanded, capitalising on the UK Government's substantial resources and reputation, to make a much bigger difference to the lives of sex workers, injecting drug users, men who have sex with men and people living with HIV/AIDS. The focus for this expanded support is contained in the recommendations.

Summary of Recommendations

Improving multilateral understanding and action on HIV and human rights

We urge the International Development Committee to recommend that the UK sponsor a resolution for the creation of the Special Rapporteur on HIV and Human Rights at the UN Human Rights Council and convene an international meeting to begin the process of developing an International HIV and Human Rights Action Plan.

Bringing greater coherence to the UK's approach to the global AIDS pandemic

We urge the International Development Committee to call on both the Department for International Development and the Foreign Office to work together to develop a UK strategy for integrated action on HIV internationally.

Providing international leadership on the rights of sexual minorities

The Alliance asks the International Development Committee to recommend to the Secretary of State for International Development and the Foreign Secretary that the UK Government appointment a Special Representative for Sexual Minority Rights, who acting within government and on behalf of the UK internationally could be tasked with developing a shared understanding of the human rights situation for sexual minorities, together with increasing the political and community support for better promotion and protection of their rights nationally and intern rights of sexual minorities.

Strategy development, implementation and monitoring

The Alliance invites the International Development Committee to recommend that the Department for International Development develop a strategy for implementing its commitment in Taking Action to vulnerable populations, which would include funding parameters and a monitoring system which can track spending and results against the strategy.

HIV/AIDS, Marginalised Populations and Emerging Epidemics

1. *The International HIV/AIDS Alliance and our special interest in HIV, marginalised populations and emerging epidemics*

The International HIV/AIDS Alliance ("the Alliance") is a partnership of organisations working together to strengthen community responses to AIDS. Established in 1993, the Alliance has a secretariat in Brighton, UK, and partners in 32 developing countries in Africa, Asia, Latin America, the Caribbean and Eastern Europe. The Alliance has a long and proud history of working with communities and sub-populations key to the dynamics of HIV transmission. These sub-populations—men who have sex with men, sex workers, injecting drug users and people with HIV/AIDS—commonly experience high levels of stigma and discrimination, are routinely denied services, and are disproportionately infected with and affected by HIV/AIDS. Despite this, our programming experience consistently illustrates how the involvement of these populations in programme design, delivery and decision making builds the skills and social capital necessary to prevent HIV transmission, and to care for, support and treat people with HIV/AIDS.

The Alliance uses the term key populations to refer collectively to sex workers, gay and other men who have sex with men and injecting drug users because these groups are key for two reasons. They are key to patterns of HIV transmission and are key to preventing and mitigating the impact of HIV/AIDS.

The Alliance's original mission centred on the human rights and epidemiological benefits of working with key populations in emerging epidemics Our experiences in working with key populations to fight AIDS in many countries for more than twelve years informs the evidence we provide here.

2. *A brief overview of populations that are key to the dynamics of the HIV epidemic*

2.1 Gay and other men who have sex with men

In a few societies sex between men is widely accepted; in some it is tolerated, and in many it is the subject of strong disapproval, legal sanctions and social taboos. Official indifference or hostility means that there are few prevention and care programmes for men who have sex with men in developing countries. It also means that little research has been undertaken to discover HIV prevalence rates, how many men are at risk and how best to provide them with the information they need to protect themselves and their sexual partners.

Sex between men, particularly anal intercourse without a condom, is one way in which HIV and other sexually transmitted infections are transmitted. Although HIV prevalence rates among men who have sex with men are high in some countries; due to the relative invisibility of male to male sex, sex between men may be an unrecognised factor in national and regional epidemics.

Where HIV prevalence is low, focusing prevention efforts on people with high risk behaviours such as men who have sex with men not only protects those individuals but can contain the epidemic at a fraction of the cost associated with a generalised epidemic. Doing this effectively requires support for both risk and vulnerability reduction interventions.

Risk reduction activities might include distributing condoms and lubricant among men who have sex with men or providing them with specifically targeted education aimed at promoting safer sex.

Supporting gay and other men who have sex with men to come together and to organize themselves for social networking, solidarity building and policy advocacy can play an important part in reducing their vulnerability.

2.2 Sex workers

Sex workers are key to the dynamics of most HIV epidemics; the potential for a large number of sexual partners increases the likelihood of exposure to HIV for sex workers and/or the possibility of exposing others to HIV.

HIV prevention in the context of sex work rests on a range of factors including the legal and policy environments in which sex work occurs; the legal, social and economic status of sex workers; and the capacity of sex workers to organise themselves and to identify and implement effective responses to the challenges they face, including HIV.

Although many countries criminalise sex work and thereby subject the act of buying or selling sex for money to criminal sanction; sex workers have the same human rights as everyone else, particularly rights to education, information, the highest attainable standard of health, and freedom from discrimination and violence, including sexual violence.

Since the beginning of the AIDS epidemic sex workers have organised around health and human rights issues, and as a result some sex worker organisations have played a crucial part in reducing HIV risk and vulnerability.

2.3 Injecting drug users

Injecting drug use is estimated to account for just less than one-third of new infections outside Sub-Saharan Africa.[5]

In spite of the importance of preventing HIV among injecting drug users, coverage of HIV prevention for this population is at best 5% globally.[6]

There are approximately 13 million injecting drug users worldwide, of whom 8.8 million live in eastern Europe and Central, South and South-East Asia. There are around 1.4 million injecting drug users in North America and 1 million in Latin America.[7]

Use of contaminated injection equipment during drug use is the major route of HIV transmission in eastern Europe and Central Asia, where it accounts for more than 80% of all HIV cases. It is also the entry point for HIV epidemics in a wide range of countries in the Middle East, North Africa, South and South-East Asia and Latin America.

Alarmingly, new epidemics of injecting drug use are being witnessed in countries of sub-Saharan Africa.[8]

[5] UNAIDS (2006). *Report on the global AIDS epidemic.* http://www.unaids.org.en/HIV data/2006GlobalReport/default.asp

[6] UNAIDS (2006). *Report on the global AIDS epidemic.*

[7] UNODC (2004). *2004 World drug report.* Vienna.

[8] Joint UNAIDS statement on HIV prevention and care strategies for drug users. Geneva. Available at http://www.unaids.org/html/pub/una-docs/cco_idupolicy_en_pdf.pdf

Beyond the physical risks associated with drug injection, drug users are vulnerable to HIV because of their social and legal status. Ironically, in many countries this means that HIV interventions are not legally available to drug users, or that drug users are unable or unwilling to access them for fear of recrimination or arrest.

2.4 Prisoners

Prisons are sites for drug use, unsafe injecting practices, tattooing with contaminated equipment, violence, rape and unprotected sex. Conditions in most prisons make them extremely high-risk environments for HIV transmission, leading them to be called "incubators" of HIV, hepatitis C and tuberculosis. They are often overcrowded and offer poor nutrition with limited access to health care.

Both male and female prisoners often come from marginalised populations, such as injecting drug users or sex workers, who are already at increased risk of HIV infection.

HIV prevention and treatment efforts in prisons should be important components of national AIDS strategies not only because of the undoubted benefits in public health terms but also as a matter of fundamental human rights.

Furthermore, most prisoners at some point return to the community. People retain the majority of their human rights when they enter prison, losing only those that are necessarily and explicitly limited because of incarceration. They retain such rights as freedom from cruel and inhuman punishment, and the right to the highest attainable standard of health care.

Over 20 years into the HIV response these populations remain key to the dynamics of the epidemic and continue to be disproportionately infected with HIV and affected by it. Unfortunately the political and institutional commitment required to address the economic, social, gender and other disparities which fuel AIDS epidemics and exacerbates its impact on people with these behaviors or in some settings remains unacceptably low.

3. *Global commitments to universal access; a world of opportunity*

The July 2005 G8 commitment to universal access to HIV treatment, care, support and prevention marked a significant development in global AIDS policy. From that momentous commitment followed the 2005 World Summit Outcome (resolution 60/1), whereby all UN Member States committed to a massive scaling up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it.

And on 2 June this year at the High Level Meting on AIDS, the UN General Assembly committed to scale up towards the goal of universal access to comprehensive HIV prevention, treatment, care and support by 2010.

These ambitious commitments have brought the AIDS response to another historic juncture. Scaling up towards universal access is an extraordinary commitment by world leaders, signalling the political will to devote the resources and energy required to end AIDS.

4. *What will constitute universal access?*

Diverse definitions for the phrase "as close as possible to universal access" emerged from these events.

The concept of universal access clearly implies that all people should have access to HIV related information and services. In early 2006 UNAIDS facilitated a global consultation process on universal access, identifying five key features of universal access:

- Accessible: locally relevant and meaningful information and services need to be available when and where people need them, and they need to be able to use them without fear of prejudice or discrimination;
- Affordable: cost should not be a barrier to commodities (eg medicines and diagnostics, condoms) and services (eg harm reduction) that exist now, and to what we hope will be developed in the future (eg microbicides and vaccines, and new medicines);
- Comprehensive: prevention, treatment, care and impact mitigation must be linked and planned and delivered with the full inclusion of people living with and affected by HIV;
- Sustainable: HIV is a lifelong challenge requiring sustained action for preventing new infections and saving and improving the quality of the lives of those with HIV; services must be available throughout people's lives rather than as one-off interventions. New technologies and approaches must continue to be developed to meet ever-changing needs; and
- Equitable: information and services must be made available to rich and poor, women and men, young and old, and to vulnerable groups, including men who have sex with men, sex workers and injecting drug users.

The spread of HIV reflects different patterns of risk and vulnerability which means that putting programmes in place which evidence these qualities will mean different things in different places.

Consequently, locally tailored prevention, treatment, care and support interventions are crucial to respond to epidemics that vary in their intensity, pace and impact in each country.

But despite local differences it is possible to say that certain behaviours and vulnerabilities together with the abject failure to provide basic HIV prevention and treatment services continue to drive the epidemic among key populations.

As a result even within countries some groups are disproportionately at risk of and affected by HIV/AIDS.If universal access is to mean anything it must address the needs of both those most vulnerable to and those most affected by HIV/AIDS.

5. *Barriers to universal access: risk, vulnerability and violations of the right to health*

In Latin America, the Caribbean, many parts of Asia and in Eastern Europe, the dynamics of HIV transmission are markedly different from those in sub-Saharan Africa. Sub-populations significant to the dynamics of HIV epidemics in these countries include men who have sex with men, sex workers, injecting drug users and prisoners.

In most countries, key populations tend to have a higher prevalence of HIV infection than that of the general population because they engage in behaviours that put them at higher risk of HIV transmission. Male to male sex, commercial sex and injecting drug use all bring high risks of HIV transmission.

In addition to increase HIV risk, these groups are almost always marginalized from society and services, experience systematic discrimination, violence and abuse.

At the same time, the resources devoted to HIV prevention, treatment and care for these populations are not proportional to the number of people living with HIV from these groups or of the impact of the virus on them. This is a serious mismanagement of resources and above all a violation of the right to health and to health care and services for individuals from these groups.

6. *HIV/AIDS is fuelled by human rights violations and human rights violations exacerbate the impact of AIDS*

Despite the fact that we have understood the relationship between HIV and human rights almost since the beginning of the epidemic,[9] human rights abuses continue to fuel AIDS and human rights violations continue to exacerbate the impact of the disease.

The destruction wrought by HIV/AIDS is fuelled by a wide range of human rights violations, including sexual violence and coercion faced by women and girls, stigmatisation of men who have sex with men, abuses against sex workers and injecting drug users, and violations of the right of young people to information on HIV transmission.

HIV prevention programmes continue to be stalled and undermined by these abuses, and assessments of the effectiveness of particular interventions continually fail to address the problem of the abjectly hostile policy environment for HIV prevention, treatment and care in the countries in which we work.

In prisons, HIV spreads with frightening efficiency due to sexual violence, lack of financial and human resources, lack of basic amenities, lack of access to condoms, lack of harm reduction measures for drug users, and lack of information.

Human rights violations only add to the stigmatisation of people at highest risk of infection and thus marginalise and drive underground those who need information, prevention services and treatment most desperately.

Abuses also follow infection. People living with HIV/AIDS are subject to stigmatisation and discrimination in society, including in their communities, in the workplace and in accessing services.

One of the most prominent and enduring insights arising out of the Alliance's HIV programming in the last twelve years is that effective prevention of the epidemic will be impossible as long as the human rights abuses that fuel infection, and follow it, go unaddressed.

7. *No commitments to vulnerability reduction*

Global HIV prevention efforts continue to prioritise risk reduction and impact reduction interventions over vulnerability reduction interventions. Programmes that provide information to drug users about safe injecting, but then jail drug users for the possession of clean injecting equipment, only to rapidly intensify their vulnerability to HIV in prison. Programmes that provide sexual health services to sex workers but then provide no protection from violence and coercion to engage in unsafe sex. Programmes that educate girls

[9] UNAIDS, *HIV/AIDS and Human Rights: International Guidelines*, September 1996.

about HIV transmission undermined by inadequate police and judicial responses to rape and by social and cultural norms that condone rape. Programmes that seek to educate men who have sex with men about HIV transmission undermined by violence, imprisonment and social exclusion.

Just as human rights are essential to reducing vulnerability and mitigating the impact of the disease, effective HIV programming depends on good governance, supportive laws and policies and the transparent and comprehensive application of the rule of law.

In many of the countries in which we are working there is a profound and widening gap between what is said about the importance of human rights in relation to fighting the epidemic, and what is actually being done.

8. *The global HIV services gap*

> *While funding for HIV programmes has increased in recent years, many countries fail to direct financial resources towards activities that address the HIV prevention needs of the populations at highest risk, opting instead to prioritise more general prevention efforts that are less cost effective and less likely to have impact on the epidemic.*
>
> UNAIDS, 2006 Report on the Global AIDS Epidemic.

The latest available data for coverage of services for HIV/AIDS prevention, care and support in low and middle income countries provides a compelling demonstration of the HIV services gap for sex workers, men who have sex with men and injecting drug users.

Data from a UNAIDS/USAID/WHO/Policy Project study[10] estimates coverage of basic HIV services for injecting drug users at an appalling 5%. The same study estimates coverage of basic HIV services for men who have sex with men at 11% and for sex workers, 16% coverage. In the UNAIDS report for 2006[11] they cite coverage data from 2005 that shows only 9% of men who have sex with men received any type of HIV prevention service in that year, and that less than 20% of injecting drug users received any HIV prevention services.

Neither of these data sets survey HIV treatment access, but we can assume that access to treatment services for these populations is even lower, given the generally very poor access to health services that marginalised populations experience, together with the continued inadequacy of treatment provision in general.

These figures undermine the optimism that accompanies announcements of increased resources for AIDS and growing political commitment to tackle the disease. These figures also highlight the systematic failure to protect the fundamental right to health of individuals from these groups.

9. *Universal access and marginalised populations—insufficient progress*

There is little evidence to suggest that the international commitments to universal access will do much to close the HIV services gap for marginalised groups.

Debate at the UN High Level Meeting on AIDS in June this year failed to generate a shared agreement about the additional risk or impact of HIV on sex workers, men who have sex with men or injecting drug users. Whilst it is possible for the UK Government to acknowledge and speak of the uneven burden of AIDS on marginalised groups, and the behaviours that create HIV risk and fuel marginalisation—risky sex, injecting—many other governments remain, after over 20 years, unable to speak about male to male sex, sex work and drug use in ways that support good public health.

From this, it also appears that the UNAIDS-led process of national target setting towards universal access will do little to address the special needs of these groups at the country level.

Early indications[12] are that very few countries have evidenced even a minimum level of commitment to these groups in their national targets for delivering universal access.

One of the chief tests of the commitment to universal access both at the national and international level must be to close the HIV services gap for those most at risk of HIV.

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[10] USAID, UNAIDS, WHO, CDC and the POLICY Project, *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003* , Washington, June 2004.

[11] UNAIDS (2006) *Report on the Global AIDS Epidemic.*

[12] Personal communication, UNAIDS staff, October 2006.

10. *Key priorities: Coherence, integration and tailoring*

Ensuring adequate funds to mount an effective global response to HIV/AIDS has been difficult. However, due in no small part to the leadership of the UK Government, over the last few years there has been an unprecedented increase in global financial resources devoted to responding to HIV/AIDS. However, this amount remains less than half of what is required by 2005, and only a quarter of what will be required by 2007 to ensure a comprehensive response to AIDS in low and middle-income countries.[13]

Unfortunately, the continued resource gap is only one of a number of funding challenges. The additional challenges include:

— inconsistent approaches from the international donor community that undermine effective country-led prevention responses in general and particularly with populations key to the epidemic in many countries;

— lack of incorporation of HIV prevention efforts into broader development strategies;

— recognising different epidemic dynamics and developing multifaceted approaches.

Inconsistent Approaches from the International Donor Community

The US Government's announcement in 2003 of some $15 billion to fight AIDS set a new global benchmark for AIDS and challenged the current levels of funding provided through the bi-lateral programmes of other large donor countries. The contribution also shifted understandings of the level of resourcing required and gave non-government and community based organisations a sense that closing the global AIDS funding gap was in fact possible.

The concept of an "emergency response" which lies at the heart of the US Government's PEPFAR programme has proved useful in bringing a sense of urgency to the global and national responses to AIDS. However, some of these new sources of funding also come with new conditions.

Whilst clear funding criteria and comprehensive monitoring and evaluation are important features of effective resource allocation, some restrictions inhibit rather than promote the design and delivery of comprehensive programmes. Such bi-lateral programmes that determine allocation of resources to donor-driven prevention priorities risk undermining interventions that have been developed based on country needs and experiences.

It is vitally important that in mobilising international resources to close the HIV/AIDS funding gap, new gaps do not develop in prevention services and programmes, especially for at risk groups. Restrictions on the nature and type of HIV prevention work that national governments and other organisations can adopt, such as responding to the HIV prevention needs of sex workers and injecting drug users, is a case in point. It is vitally important that HIV prevention interventions do not unintentionally reinforce existing discriminatory approaches to key populations.

It is also vitally important that our prevention efforts are guided by evidence demonstrating effectiveness, by principles of equity and by a focus on impact. Funding mechanisms must be fluid and responsive to different dynamics in the epidemic, and to the evidence emerging from all levels of programming. Ideological opposition to, for example, building the capacity of sex workers or young women to protect themselves from HIV, must be challenged in a global HIV prevention strategy.

Standard HIV prevention interventions—HIV/AIDS awareness campaigns, voluntary counseling and testing, and accessible STD treatment—apply to all epidemics, but our experience of working with many different communities highlights how very diverse the HIV epidemic is. Tailoring multi-faceted prevention strategies to specifically address national and local needs is critically important to national prevention planning.

Multi-lateral funding mechanisms such as the World Bank MAP programme and the Global Fund allow for country-driven prevention responses and must be supported in any global HIV prevention strategy. The success of prevention programmes will ultimately depend on coordinated, scaled up country action.

National governments, in partnership with civil society and affected communities, must drive the process of expanding prevention services and their specific needs and capacities will shape their own strategies and their scaled up activities.

Incorporating HIV into Broader Development Strategies

HIV/AIDS plays a central role in the development agenda and development efforts must be designed to reduce inequalities that increase vulnerability to HIV.

Although some progress has been made in adapting development policies and programmes to respond more appropriately to HIV, much more needs to be done. In particular, development efforts must be designed to reduce gender inequities and enhance economic and political opportunities for women and girls.

[13] *Financial resources for HIV/AIDS programmes in low- and middle-income countries over the next five years.* UNAIDS, November 2002.

The inextricable links between poverty, HIV vulnerability and the ever-increasing impact of the epidemic are well established, but these links remain largely unaddressed in HIV programming.

In many developing countries HIV prevention continues to inadequately address the causes and consequences of social and economic deprivation, which in turn lead to HIV vulnerability.

HIV/AIDS programming must therefore:

— be integrated into poverty alleviation strategies;

— feed into the assessments and analysis of human vulnerability and livelihood strategies;

— be more effectively integrated into, and strengthen, existing sexual and reproductive health services; and

— revitalise some of the fundamental approaches to public and primary health care developed over previous decades.

Development policies need to be sensitive to the exclusion and inequality experienced by people with HIV/AIDS and populations particularly vulnerable to HIV, including sex workers, men who have sex with men and injecting drug users.

HIV prevention strategies need to be included much more extensively within Poverty Reduction Strategy Papers and all other country led development strategies.

Recognising Different Epidemic Dynamics and Developing a Multifaceted Approach

We must acknowledge that distinct epidemics require distinct approaches. One size does not fit all. This is the case for both countries with generalised and concentrated epidemics. Greater attention has to be given to understanding transmission patterns in each different context. Greater attention and time to social ethnography and community mapping is critically important to planning effective interventions as they provide both evidence about transmission dynamics and HIV prevention need—the "blueprint" for HIV prevention planning.

This is particularly the case in mapping out and designing effective responses for countries currently experiencing concentrated epidemics. It is essential that we do not shy away from recognising that transmission is occurring amongst priority groups and set out measures to protect them.

The Alliance Frontiers Prevention Programme (FPP) aims to make a significant contribution to reducing HIV infection in three relatively low prevalence countries—India, Cambodia and Ecuador—by working alongside key populations (sex workers, injecting drug users and men who have sex with men), delivering a comprehensive package of interventions within specific geographical sites that are seen as potential high HIV transmission areas. Addressing the HIV prevention needs of populations key to HIV epidemics has the potential to reduce the overall impact on the general population.

11. *The UK Government's response; opportunities to make a world of difference*

The UK Government's response to the HIV needs of key populations is undeniably moving in the right direction but with relatively small modifications the UK could make a much greater contribution, including through:

— improved international political and policy leadership;

— improving multilateral understanding and action on HIV and human rights;

— bringing greater coherence to the UK's approach to the global AIDS pandemic;

— providing international leadership on the rights of sexual minorities;

— strategy development, implementation and monitoring.

Improved International Political and Policy Leadership

In its leadership role in international policy fora, the UK Government, specifically Secretary of State Hilary Benn, Minister for International Development Gareth Thomas, and senior DFID officials remain strong and outspoken supporters of the rights of marginalised populations to access services, and to protection from human rights violations. This work is rare and precious in environments where it is much easier for leaders to speak about mothers and children than it is to speak about male to male sex and injecting drug use, as the Secretary of State did at UN High Level Meeting in June this year. Similarly the EU's statement on HIV prevention launched on World AIDS Day last year during the UK's Presidency, the UK's own statement on injecting drug use and harm minimisation and the commitment to fighting for evidence based prevention in the UNAIDS HIV prevention strategy process—are all enormously important examples of progressive policy leadership which the Alliance applauds.

However we believe that the UK Government could make a vital contribution to progress in this area by taking the initiative in the following areas.

Improving Multilateral Understanding and Action on HIV and Human Rights

As already stated while there is widespread, though not universal, recognition that stigma and other rights violations fuel the epidemic and that many people's rights are seriously harmed by HIV, these basic understandings are not adequately reflected in law and policy, or in HIV programming.The move towards universal access to prevention, care and treatment demonstrates the potential of concerted international attention and action. We need to see the same focus given to protecting and advancing the human rights of those most affected by HIV and AIDS.

The UN Secretary General's Note, *Scaling up HIV prevention, treatment, care and support*,[14] describes in detail some of the necessary human rights interventions to bring about universal access, but these interventions do not appear in the Political Statement arising out the High Level Meeting or in any international action plans.

We are calling for the development and implementation of a global action plan on HIV and human rights which would help mobilise national, regional and international action to protect and to promote human rights—thereby helping to prevent HIV and mitigate its most negative effects.

The plan would identify those actions necessary to advance human rights, focusing on reducing HIV vulnerability and protecting the rights of affected communities. Following its development, international expertise and funding could be identified to help the UN, Member States and civil society implement the plan.

We also believe that the international community in general and the UN system in particular needs to enhance its understanding of the human rights violations which fuel the epidemic and which also follow infection. Above all they must understand how to protect and promote people whose rights are all too routinely violated.

Whilst the Alliance welcomes the integration of HIV/AIDS into the work of some of the UN's human rights mechanisms, the relationship between HIV/AIDS and human rights violations continues to go unaddressed in a variety of UN fora.

In order to help overcome this problem and to create a focal point for analysis and policy development at the UN we are proposing the appointment of a Special Rapporteur on HIV and Human Rights by the new UN Human Rights Council. The Special Rapporteur would act as the focal point for UNAIDS' work in leading the development and implementation of the Human Rights Action Plan recommended above, and would make an important contribution to generating the interest and political will necessary with the UN family and among member states for the UN to tackle HIV-related human rights violations.

It is very clear that a step change in our commitment to human rights is necessary if we are going to make them a reality for people living with and affected by HIV. The changes needed to achieve this at the international level will only come about if there is a clear focus backed up by an ambitious and funded plan.

We urge the International Development Committee to recommend that the UK sponsor a resolution for the creation of the Special Rapporteur on HIV and Human Rights at the UN Human Rights Council and convene an international meeting to begin the process of developing an International HIV and Human Rights Action Plan.

Bringing Greater Coherence to the UK's Approach to the Global AIDS Pandemic

Whilst the role of the Foreign Office in advocating for a progressive approach to AIDS through its international policy and diplomatic efforts is referred to briefly in *Taking Action* there is little evidence to suggest that the Government has a coherent strategy for implementing that approach.

Significant gains in HIV prevention and impact mitigation could be made through UK efforts outside the remit of the Department for International Development. The Foreign Office's efforts aimed at promoting good governance, respect for human rights, democratic principles and sound management of natural resources through programs such as the Global Opportunities Fund do not currently adequately consider opportunities to advance the UK's commitment to universal access to HIV treatment, prevention and care.

We believe that opportunities also exist to promote the UK's HIV related foreign and development policy through better use of the FCO's public diplomacy, drugs and crime and global conflict prevention programs.

We urge the International Development Committee to call on both DFID and the Foreign Office to work together to develop a UK strategy for integrated action on HIV internationally.

Providing International Leadership on the Rights of Sexual Minorities

The rights of sexual minorities are amongst the least recognised and protected in international law and national practice.

The failure to recognise sexual minority rights and to provide protection for them fuels an AIDS pandemic and inhibits effective responses to it.

[14] www.unaids.org

The UK has an excellent record domestically on advancing the rights and status of sexual minorities including gay and other men who have sex with men, transgender and intersex persons and is therefore well placed to leverage its commitment at home for improvements in the situation for individuals from these groups internationally.

To begin that process the Alliance is asking the International Development Committee to recommend that the UK Government appointment a Special Representative for Sexual Minority Rights.

The appointment of a Special Representative on Climate Change within the Foreign and Commonwealth Office[15] provides a model for these recommendations.

The UK has a very extensive diplomatic network and powerful diplomatic assets which it can deploy in pursuit of this exercise and in support of its stated commitment to universal access for marginalised groups. A Special Representative acting within government and on behalf of the UK internationally could be tasked with developing a shared understanding of the human rights situation for sexual minorities together with increasing the political and community support for better promotion and protection of their rights nationally and intern rights of sexual minorities.

Strategy Development, Implementation and Monitoring

DFID's AIDS Strategy, *Taking Action*, refers to vulnerable populations consistently, but without setting out any specific actions to guide DFID programming. Despite this, we know that DFID support work with men who have sex with men in Latin America and the Caribbean, with drug users in China, and with sex workers in Cambodia. What this work lacks however, is a unified and demonstrable strategy that sets out work with vulnerable populations as a high priority in terms of its in-country programmes, and that allocates specific resources towards meeting the HIV related needs of these groups, supporting efforts that protect and promote their rights and closing the HIV services gap for them.

The absence of a more developed policy and an action plan, with a system for allocating and monitoring resource use means that it is currently impossible to properly assess DFID's commitment to and action in this area.

Without such a plan the UK will not be able to assess whether it is doing enough at sufficient speed to improve the situation for members of key populations affected by HIV in the developing world.

DFID's higher corporate goals to address the world's poorest people can lead to some conflict of purpose here. Addressing highly vulnerable populations in emerging HIV epidemics requires a shift in broader DFID policy that currently prioritises its support to highly impoverished countries, namely many African countries. Given that the highest burden of AIDS remains in Africa, it is entirely appropriate that Africa remains the central focus for DFID's AIDS spend, but it must not be at the exclusion of work with marginalised populations in concentrated or emerging epidemics.

The Alliance invites the International Development Committee to recommend that the Secretary for State instruct the Department for International Development to develop a strategy for implementing its commitments in *Taking Action* for vulnerable populations, which would include funding parameters and a monitoring system which can track spending and results against the strategy.

October 2006

Memorandum submitted by Naz Foundation International

1. Executive Summary

1.1 Male to male sex in South Asia is diverse, with many males who have sex with males (MSM) having indigenous, no, or to a much lesser extent, western style identities.

1.2 Gender identity is also important in relation to male to male sex in South Asia.

1.3 High levels of HIV risk taking behaviour between males in South Asia is evident.

1.4 We find high levels of HIV amongst some MSM populations (estimated to be a 10% HIV prevalence in India), to emerging epidemics in others (estimated to be a 2% HIV prevalence in Pakistan, and a 1% HIV prevalence in Bangladesh).

1.5 High levels of untreated sexually transmitted infections and genito-urinary complaints further increase HIV acquisition and transmission risk.

1.6 Stigma and discrimination of MSM leads to their increased vulnerability to HIV.

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[15] *Margaret Beckett appoints New Climate Change Representative*, 08/06/06, viewed at http://www.fco.gov.uk/servlet/Front?pagename=OpenMarket/Xcelerate/ShowPage&c=Page&cid=1007029391638&a=K Article&aid=1148476529299

1.7 Provision of appropriate HIV related services for MSM in South Asia is relatively new.

1.8 Whilst there has been some development of services, not all services are appropriate.

1.9 Support for appropriate HIV interventions for MSM from national governments in the region vary.

1.10 Coverage of HIV services for MSM is not well understood, but we estimate this to be poor, certainly for care and support services for MSM infected with HIV.

1.11 DFID, the EU, the UN and NGOs have a role to play in ensuring universal access to appropriate HIV services for MSM in South Asia, by policy development, advocacy, financial and other support.

1.12 DFID should continue to support the strategic development of appropriate MSM HIV services in South Asia, continue to, and increase support to MSM HIV interventions in the region, and to ensure these activities are sustained.

1.13 DFID needs to provide leadership and support to UNAIDS and others, to ensure universal access to HIV services for MSM in South Asia.

1.14 DFID needs to allocate financial resources in accordance with the priority it gives to MSM and HIV in its HIV strategy to ensure the issue is appropriately addressed, and to ensure that this strategy meets the needs of MSM and HIV.

1.15 This committee should ask DFID to assess the coverage of MSM and HIV related services in South Asia, how their current HIV strategy will ensure universal access to HIV services for MSM, and what changes they might need to make to their strategy to ensure this universal access.

2. Introduction to Submitter

2.1 I have been working on HIV and AIDS issues since 1989. I have a wide range of experience of working on HIV and AIDS issues which includes:

- Developing a syringe exchange scheme for injecting drug users in London, providing clean injecting equipment and information on safer injecting practices.
- Working with people with same gender attraction from minority ethnic, providing information on HIV, AIDS and safer sex.
- Developing services for minority ethnic communities, providing information, advice, counselling and support around HIV and AIDS in the UK, and providing support for this work across Europe.
- Developing, and advocating for appropriate HIV related services for males who have sex with males in Asia, other resource-poor settings and elsewhere.
- Advocating for microbicides and other new HIV prevention technologies.

2.2 I have particular expertise in a number of areas related to HIV, which are:

- Understanding behaviour, identity and HIV risk factors of MSM in South Asia and elsewhere.
- Designing, developing, supporting and implementing HIV prevention and support, particularly for hard to reach communities, both in the UK and in resource-poor settings, particularly in South Asia.
- Advocacy and policy development around HIV related prevention, support and care for MSM in South Asia and elsewhere.

3. Factual Information

3.1 For drawing conclusions from, or putting to other witnesses.

3.2 Holding the UK Government to account for the commitment it made during 2005 to support international efforts, led by UNAIDS, to achieve the goal of universal access to HIV/AIDS prevention, treatment, care and support for all those who need it, by 2010. The provision of HIV/AIDS prevention, treatment, care and support to males who have sex with males in South Asia. Our knowledge of the contribution of DFID in addressing these issues, and the role of the EU, UN and non-governmental organisations.

3.2.1 Our current knowledge of the HIV epidemics amongst males who have sex with males (MSM) in South Asia. Identity, behaviour and HIV risk factors. The role of male to male sex in wider-population level epidemics.

3.2.1.1 The existence of male to male sex in South Asia has often been denied, although the work of the Naz Foundation International[16] and others, has documented wide-spread male to male sex, across social, economic and religious line in South Asia. As in the West, there are MSM who take on a "gay" identity, but these tend to be richer, middle class men, who live in major urban areas, and are able to resist marriage. For the remainder of MSM in South Asia, they tend to be married, and to exhibit a range of sexualities,

[16] See http://www.nfi.net/assessments.htm for more details.

genders and behaviours. Our research has shown both indigenous and developing sexualities of males in this region. For example, in South Asia, we find many MSM who, whilst married, and taking on a male identity when with their wife, cross-dress, wear make-up, and take on "feminine" mannerisms, with a view to finding "manly" sexual partners. They even have their own identity, *kothi* in India, *zenana* in Pakistan, and *meti* in Nepal. Their male sexual partners though usually have no specific identity related to their male to male sex practices, although the *kothis* in India label them as *panthis*. The *kothis* in India also have a term for a man they deem to be their male husband, a *parik*. The point here being that, we find both established indigenous differing identities, and non-identifying MSM. *Kothis* and their equivalent elsewhere, tend not to have formed communities, but have tended to be isolated from each other. In South Asia, we also find communities of MSM who cross-dress all the time, take on a "feminine" identity, but usually identify as not a man or a women, but a third gender. In India they are known as *hijra*. *Hijra* live in closely knit communities, with a *guru*, heading up a clan of *chela* (her disciples). There can be many such communities in an urban area in South Asia. Boys and young men who join a *hijra* communities will certainly cross-dress, and many of them will be castrated, usually by member of the *hijra* community, and there is anecdotal evidence that castration practices are increasing. *Hijras* have sex with other males, either for pleasure, for money, or because they are forced to. Both *kothis* and *hijras* (and their equivalents elsewhere in South Asia) tend to be sexually penetrated. As mentioned before, both *kothis* and *hijras* tend to have sex with those who do not identify as an MSM, and there is a growing body of evidence that suggests that male to male sex in South Asia is very common. For example, a study of truck drivers in Lahore, Pakistan, showed that 49% had had sex with another male[17], often this sex would be with their male help or a male sex worker.

3.2.1.2 From our assessments[18], we find high levels of unprotected anal sex between feminised males and other males. Also we have evidence that *kothis* are more highly sexed with their female partners than non-*kothi* males. As mentioned earlier, the *kothis* and *hijras* tend to be anally penetrated. Other male to male sexual behaviour, such as oral sex, masturbation, and thigh sex, where the penis is placed between the (usually the feminised) male's thighs, and rubbed to and fro are commonly found. We also find that many of these marginalised, and here we refer to *kothis*, *hijras* and their like, often have many sexual partners. For example, in recent study in Sylhet, Bangladesh, 20% of the MSM we talked to had had between 11 and 15 male sexual partners in the last month. In addition to sex for pleasure, many of the marginalised males sell sex for cash and favours, or are forced on many occasions to have sex (by the police, local thugs etc). We find relatively low levels of condom use in areas where there have been no, or little HIV related interventions specifically for MSM. In the same study just referred to, condoms were used in only 31% of anal receptive sex acts. We find this is in part due to lack of access to condoms and suitable lubricant, discrimination against those who carry these by the police and others (male to male sex is illegal across South Asia), lack of knowledge regarding HIV transmission, and low self-esteem, meaning that many MSM do not care if they become infected with HIV or not. These marginalised males often find sexual partners in public "cruising" sites, such as parks, toilets and railway tracks, which offer some fairly private place to go and have sex. Other sex between males is almost encouraged by the very homosocial spaces we find in South Asia, where brothers, cousins, uncles etc, share beds with other males, males work together, and all-male institutions such as the military, prisons etc are common. We have reports of much situational male to male sex occurring, although often this sex is as hidden as it can be, and usually not discussed.

3.2.1.3 In terms of male to male sex, and the risk of acquiring or transmitting HIV, there are a number of risk factors:

- The high levels of unprotected anal sex we find amongst MSM.
- The high numbers of sexual partners we find amongst MSM.
- High levels of sexually transmitted infections (STIs), and other genito-urinary diseases (GUDs). For example, in all of our studies, we find MSM populations with high levels of untreated STIs and GUDs, or where treated, this is usually self-treated, often poorly. STIs and GUDs have been shown to heighten the risk of acquiring HIV.
- High levels of stigma and discrimination against MSM and male to male sex. This results in discrimination against males who show feminine characteristics at home, at school and in the workplace, resulting in lower self-esteem, lower educational achievements, and lower chances of sufficiently economic employment. This leads often to sex work, as a means of survival, with associated risks of acquiring HIV from multiple partners, lack of consistent condom use and sexual abuse. More information on stigma and discrimination around male to male sex and its effect on HIV vulnerability can be found in a recent study and report we undertook on behalf of the British Foreign and Commonwealth Office, looking at this issue in India and Bangladesh, and a copy of this report entitled "From the front line" can be obtained on our website[19].

3.2.2 Provision of HIV related services for MSM in South Asia so far and in the future.

3.2.2.1 When we started addressing male to male sex and HIV issues in South Asia in 1996, there were very few interventions addressing this issue. What existed, often focussed on forwarding a "gay" agenda, and was mainly restricted to more wealthy middle class males in urban areas in India. We have since 1996

[17] Khan OA, Hyder AA. *HIV/AIDS among men who have sex with men in Pakistan.* Sex Health Exch 1998; Vol 2: 12–13,15.
[18] See http://www.nfi.net/assessments.htm for more details.
[19] http://www.nfi.net/

though, helped establish over 50 community based interventions addressing MSM and HIV issues in the region. Together with this, other individuals and organisations have established HIV related services that target MSM in the region. We use a community development model, where we identify interested MSM in a particular area, train them on undertaking a needs assessment with respect to MSM and HIV in their local area, work with them to undertake this needs assessment, then help them develop and maintain a community based organisations to respond to these and changing needs. Many of these organisations have been successful in obtaining funds to continue their work from the local government (in India), international private sources, or bilateral donor aid. Initially these community based organisations (CBOs) were based in their state, or in the case of Bangladesh and Nepal, country capitals. With support from my organisation, we have helped these organisations expand their operations in other cities and areas in their states/countries, to increase coverage of services to MSM. Since March 2006, with support from DFID in India, we have been scaling up MSM and HIV related interventions in four states in India (Andra Pradesh, Karnataka, Tamil Nadu, and Uttar Pradesh), developing nine new MSM CBOs providing MSM and HIV interventions in each of these states. In addition to the stigma and discrimination study undertaken in India and Bangladesh, we developed the capacity of a number of CBOs in India and Bangladesh to form working groups to monitor human rights abuses for MSM, and to also deal with these issues at national levels. This work is ongoing, and DFID India is supporting this work there. In our studies, we find that most condoms were not used with a suitable water-based lubricant, which is essential to ensure they afford appropriate protection. There are a number of reasons for this, in part due to the cost of the then available lubricants, the fact that carrying this lubricant could result in harassment from the police and others, and lack of knowledge about the need for such a lubricant. To help address these problems, we have developed a low-cost, small-sized lubricant sachet, aimed at MSM in South Asia, which funding again from DFID in India, and are currently testing this for user acceptability. The network of MSM CBOs we have developed, continues to be supported by our organisation, where we provide technical support around program management, fundraising and advocacy work. This happens both locally, and at our training centre we have established in Lucknow, northern India. We have also developed a resource centre in Lucknow, which contains a variety of printed resources to help MSM and HIV programming and policy work, that our partners and others can access. Our website also contains resources that can be use to inform policy and programming on MSM and HIV issues.

3.2.2.2 Support for MSM and HIV work by national governments varies across South Asia. MSM were included in the second national AIDS plan of India, and are included in the newly published third plan, though we have a concern that whilst they acknowledge the benefit of having MSM communities providing HIV services to themselves (which is essential if appropriate services are to be providing for many services), this is not always the approach they will take. We have received many reports of non-governmental organisations with little or no experience of working with MSM being contracted to provided HIV services for MSM in totally inappropriate ways in India. Bangladesh though whilst allowing work with MSM, have not been supportive in terms of providing funds for this work. The Nepalese government is showing signs for supporting the work on MSM there, through the Blue Diamond Society, an MSM CBO we helped establish. In Pakistan, with support from the World Bank, we have been undertaking some preparatory needs assessments, and community development activities, with a view to establishing MSM HIV services provided by and for MSM.

3.2.2.3 There are other non-governmental organisations providing services which might reach, or are meant to reach MSM, but as mentioned above, often they fail to make these services appropriate, and do not employ suitably knowledgeable or qualified people.

3.2.2.4 In terms of what appropriate services are being provided, these can be detailed as:

- Peer education and outreach to sites where MSM meet for sex. Provision of condoms and sometimes water-based lubricant and information and advice on safer sex and other HIV related issues. Befriending, and referral to health care, social support and other services for MSM.
- Provision of drop-in and safe social spaces for MSM to meet in.
- Provision of education on safer sex, and HIV related issues.
- Provision of vocation training.
- Provision of clinical services to treat sexually transmitted infections and other genito-urinary complaints. Referral to other health-care services.
- Provision of support around welfare and human rights, and advocacy around these issues.

3.2.2.5 Very little work is being done with regards to MSM who are infected with HIV, although we, with our partner organisations hope to develop community care services for MSM living with HIV.

3.2.2.6 In terms of estimating the coverage of services for MSM, we face two major challenges, firstly to establish the size of any at-risk MSM population, and secondly, then to assess how many of these at-risk MSM are being targeted by appropriate and sufficient interventions. Given these challenges, some work has been done to attempt to give a figure for service coverage, and coverage estimates vary between 4%[20] and

[20] Stover, J, and M Fahnestock. 2006. *Coverage of Selected Services for HIV/AIDS Prevention, Care and Treatment in Low- and Middle-income Countries in 2005*. Washington, DC: Constella Futures, POLICY Project. Definition used is "percentage of MSM receiving outreach".

45%[21] of MSM receiving HIV prevention services in India, 77%[22] receiving HIV prevention services in Bangladesh, 22%[23] to 15%[24] receiving HIV prevention services in Pakistan, and 5%[25] to 36%[26] receiving HIV prevention services in Nepal. From our estimates of the numbers of MSM requiring HIV prevention services though in these countries, and the provision of services we know about, it is likely that the true coverage is much lower than these figures suggest. In terms of care and support for MSM living with HIV, the coverage is almost 0%. Access to treatment for MSM is also very poor, as they are often discriminated against in access to healthcare services, and there are no reliable figures for the number of MSM infected with HIV receiving treatment as far as we know.

3.2.2.7 We plan, with our partner organisations, to scale-up coverage of HIV prevention services for MSM in these countries, and to develop, and scale up support and care services for MSM, and referral to HIV treatment services, and work to ensure these HIV treatment services are appropriate for MSM. We will continue to advocate for the provision of appropriate HIV prevention, care, support and treatment services for MSM, and work with others to ensure access to these services.

3.2.3 The role of DFID, the EU, the UN and NGOs in supporting universal access to HIV prevention, treatment, care and support for MSM in South Asia.

3.2.3.1 DFID has a role, together with other bilateral and other donors, and the governments in South Asia, to ensure those MSM that need HIV prevention, support, care and treatment services receive them. DFID's role in this can be:

- To help assess the need.
- To develop policies on appropriate service provision.
- To support these nations to implement these policies.
- To help these countries tackle the stigma and discrimination MSM face.
- To provide support to organisations developing appropriate HIV interventions for MSM in these countries.
- To work with other donors to ensure that an appropriate knowledge base, supportive policy environment, and funding sources exist to enable sufficient coverage of necessary HIV services for MSM in these countries.

3.2.3.2 DFID has played an important role so far in advocating for work with marginalised communities in South Asia, and their recent support of an international consultation meeting on MSM and HIV for the Asia and Pacific (see http://www.risksandresponsibilities.org/ for more details), that we helped organise, show their commitment to this work. DFID though has an important strategic role it needs to fulfil, in trying to ensure universal access to prevention, care, support and treatment with regards to HIV for MSM. DFID has provided support to our organisation to undertake a strategic development role around HIV services for MSM in South Asia, although currently this support is ceasing, and without this continued support, it is not clear that we can continue to provide this support to this work, meaning that providing coverage of appropriate MSM and HIV services in South Asia might well not happen, and certainly not in a timely fashion (as this role would have to be reinvented somewhere), without the strategic co-ordination, advocacy and implementation work we would otherwise do.

3.2.3.3 DFID can, through bilateral aid, support national governments in implementing their national AIDS plans, but it is important, that DFID ensure that these plans are appropriate to the needs of MSM.

3.2.3.4 The EU can, in addition to the GFATM, and bilateral donors, support community based interventions addressing MSM and HIV, developing on established models of good practice, and helping to scale-up interventions.

3.2.3.5 The UN's role, through UNAIDS, and the organisations that make this up (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, and the World Bank), provide leadership, policy advice and advocacy, co-ordination, and support to knowledge generation and management activities, and support specific work where required, to ensure that male to male sex and HIV are better understood in these countries, that they are appropriate addressed in national, and local HIV and AIDS plans, that sufficient financial resources are available to address MSM and HIV issues identified, and that this work is undertaken in a timely manner.

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[21] UNAIDS. 2006. 2006 Report on the Global AIDS Epidemic. Geneva: UNAIDS. Definition used is percentage of MSM receiving one of the following services: community outreach programs that included peer education, exposure to mass media, and sexually transmitted infection screening or treatment programme.

[22] *Ibid.*

[23] *Ibid.*

[24] *Ibid* reference 20.

[25] *Ibid* reference 21.

[26] *Ibid* reference 20.

3.2.3.6 NGO's can work with the governments, each other, and external actors, to help develop and advocate for appropriate policies with regards to MSM and HIV, and where appropriate, usually through MSM CBOs, provide direct HIV services to MSM. NGOs that are donors, such as the Bill and Melinda Gates Foundation, should also address MSM and HIV appropriately, and support the development of appropriate policies and interventions.

3.3 The extent to which HIV/AIDS policy and programming is effectively addressing emerging epidemics, including those in Eastern Europe and Asia. Our knowledge of the contribution of DFID in addressing these issues, and the role of the EU, UN and non-governmental organisations.

3.3.1 Evidence we have gained regarding the incidence and prevalence of HIV amongst MSM in South Asia suggest that we have both emerging, and well established HIV epidemics amongst these communities. An analysis of published data on HIV prevalence figures for India, Pakistan and Bangladesh, suggest HIV prevalence figures of approximately 10%, 2% and 1% amongst at HIV-risk MSM in these countries respectively. Published data though suggests pockets of much higher HIV prevalence in some areas, although the data on this is sparse and unreliable. We can conclude though, that in India, we have both an established and emerging epidemic amongst MSM, and in Pakistan and Bangladesh, emerging epidemics. It is not clear what is happened elsewhere in South Asia with regards to MSM and HIV prevalence and incidence. DFID's policy of addressing marginalised communities, such as MSM is good in terms of aiming to address MSM and HIV issues, but what is important, is to ensure the provision of:

- Sufficient coverage of appropriate HIV prevention services.
- Sufficient coverage of HIV care, support and treatment services (this synergistically supports prevention work).
- Support to work tackling stigma and discrimination around male to male sex and gender issues.

3.3.2 It is not clear how DFID's current work acts strategically to ensure this.

3.3.3 I do not have any specific evidence to provide on the EU with regards to this matter, as we have not worked with them in any depth on this issue yet.

3.3.4 With regards to the UN, UNAIDS has specifically addressed MSM and HIV in the recent past, and a recent policy position paper on MSM goes along way to frame a supporting policy framework for appropriate work around MSM and HIV.

3.3.5 NGOs, both internal to these countries and externally have a role to play, in terms of developing and advocating for appropriate policies to address these epidemics, to develop appropriate interventions, and to support financially, and in kind these interventions.

3.4 Recommendations for action by the Government and others.

3.4.1 That DFID needs to ensure a strategic development approach to MSM and HIV in South Asia, and to support our work in this regard.

3.4.2 That DFID needs to continue, and increase support for the development of community based interventions on HIV prevention, support and care for MSM in South Asia.

3.4.3 That DFID ensure that MSM and HIV related strategic development and interventions are sustained in the long-term.

3.4.4 That DFID continues to prioritise the needs of MSM with regards to HIV, and undertake additional work, to ensure that their needs are sufficiently well understood, and that good practice with regards appropriate HIV and related interventions are recognised and developed.

3.4.5 That DFID regularly review their HIV development strategy, to ensure it support the universal access to HIV services for MSM in South Asia and elsewhere in developing areas.

3.4.6 That DFID ensures the money it spends on HIV related work is in accordance with its priority for MSM related work.

3.4.7 That DFID provides a leadership role, in advocating for a co-ordinated donor response to MSM and HIV across South Asia and elsewhere.

3.4.8 The DFID encourages UNAIDS to develop its strategic leadership and brokering role, to ensure coverage of MSM and HIV services in South Asia and elsewhere.

3.4.9 That DFID develop a focal point on vulnerable communities, including MSM, to develop good practice with regards to policy and programme for these communities.

3.4.10 The NGOs, where appropriate develop MSM and HIV services, and support the development of these programmes, appropriate policies, and advocate for these.

3.4.11 That this committee asks DFID to report on the coverage of MSM and HIV related services in South Asia and other developing areas, and details their strategy in ensuring universal access to HIV services for MSM in these areas.

Kim Mulji

October 2006

Memorandum submitted by the African HIV Policy Network

1. The African HIV Policy Network

1.1 The AHPN is an alliance of African community-based organisations and their supporters working for fair policies for people living with HIV/AIDS in the UK, providing training, support, research and information. The AHPN is the only African organisation in the UK whose work is dedicated to policy, advocacy and representation at national level. Its major focus is on HIV and the sexual health of Africans in the UK.

2. Experiences and Needs of African People Living with HIV in the UK

2.1 There are estimated to be more than 11,000 African people living with diagnosed infection in the UK (HPA, 2005). In addition several thousand more African people living in the UK have undiagnosed HIV infection since studies have shown that roughly two-thirds of African people in the UK have never tested for HIV (Fenton *et al,* 2002). HIV prevalence is many times higher among African people in the UK than among the White British majority. Compared to UK born men and women attending GUM clinics (each of whom have an HIV prevalence of 0.2%), 7.7% of African born women and 4.8% of African born men who attend GUM clinics are infected with HIV.

2.2 A recent quantitative study (Weatherburn *et al,* 2003) which included an analysis of the health and social needs of African people with HIV shows that between a half and three quarters of this group report significant ongoing difficulties in the following areas: income, immigration status, housing and living conditions, and access to training, skills and job opportunities. Difficulties in meeting these basic needs clearly lead to reduced quality of life. Similar percentages said they had significant and ongoing difficulties associated with anxiety and depression, their ability to sleep, their self-confidence and their personal relationships. The same study compared the experiences of African people with HIV to their White British counterparts. Compared to other people with HIV in the UK, African people with HIV were 10 times more likely to report problems associated with their income, seven times more likely to report problems with their living conditions, three times more likely to report problems with discrimination and twice as likely to report problems with getting about (mobility) and personal relationships.

2.3 Thus, not only are African people with HIV likely to experience more health and social care needs than the general population, but they also experience more needs than British people with HIV. Social exclusion is undoubtedly exacerbated by factors associated with migrancy. It's likely that a significant proportion of African people with HIV in the UK are (or have been in the past) refugees or asylum seekers (Fortier, 2004), a group already significantly socially excluded (refugee council, 2004a). Exclusion associated with being HIV positive may be significantly compounded by pre-existing social exclusion and social need associated with being an African refugee or asylum seeker.

2.4 In order to survive and thrive, refugees and asylum seekers need to draw on their own personal resources (their ability to work for example) and need to draw on a supportive social environment in their host country. This environment is created first by the support of expatriate communities in the host country as well as in their home country and second by the provision of supportive enabling legislation policy and services by the host country. African people with HIV are likely to have all of these resources particularly curtailed.

3. Treatment Access

3.1 In July 2005, the UK played a significant role in getting the G8 countries to pledge their support for universal access to HIV treatment worldwide by 2010. This lofty goal was later endorsed by all United Nations member states where they obligated themselves to:

3.2 *"Developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it".*

3.3 In May–June 2006 this promise was again ratified in the UNGASS Declaration of Commitment:

3.4 *"[We commit] to pursue all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010."*

3.5 The leaders also agreed to: *"set in 2006, through inclusive, transparent processes, ambitious national targets, including interim targets for 2008 . . . that reflect . . . the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010."*

3.6 Despite the UK government's very visible leadership and commitment to universal access to HIV treatment, it has not shown an equally brave face on its own front door.

3.7 In April 2004, in response to the tabloid press claim of "treatment tourism", the Government introduced changes to NHS policy concerning HIV treatment for overseas visitors to the UK. Beforehand, NHS treatment for all conditions was free for anyone who had lived in the UK for at least 12 months, including anyone applying for asylum or the right to remain in the country; which allowed the majority of overseas visitors who required HIV medication to obtain it without charge. The new changes say that anyone living in the UK without documentation, and anyone refused asylum or leave to remain, but not removed from the UK, must pay for HIV treatment except in emergencies.

3.8 This policy is inhumane and unethical, as it targets those most vulnerable from the developing world. These proposals would accentuate inequalities rather address them. Charging undocumented migrants, failed asylum seekers, or visitors with HIV/AIDS, runs counter to public health interests. Seeking funds from those who are unlikely to possess them is neither cost effective nor productive. Such measures also run the risk of driving HIV underground, and increase the burden on NHS A and E services.

3.9 The legislation singles out HIV for charges, while other communicable diseases and sexually transmitted infections remain free to everyone, including accident and emergency services.

3.10 HIV was singled out, because of the fear that free treatment will bring a flood of people from countries where none is available, putting the NHS under strain and public health at risk. The existence of supposed "health tourism" to which this measure is clearly a reaction to has not been proven and is contradicted by a House of Commons Health Committee report (2005). The report issued in response to the Department of Health's policy, stated that the majority of overseas visitors infected with HIV do not access NHS help until the later stages of their condition when they are seriously ill. The same report they argued that people with untreated HIV patients will make increasing visits to A&E departments, costing the NHS more in emergency treatment than it would to provide long-term medication.

3.11 There is a greater risk of HIV being transmitted by untreated individuals. Free screening and counselling is available to all those residing in the UK regardless of residency status, evidence demonstrate that people are much more likely to get themselves tested for HIV in countries where treatment is available than those where there is no access to treatment. The knowledge that they are not allowed treatment might stop immigrants from getting screened for HIV, posing a further possible risk to public health, as more cases of HIV are likely to go undiagnosed.

4. Recommendation

4.1 The UK government should exempt HIV treatment from the NHS charges for overseas visitors rules.

5. Deportation

5.1 On 5 May 2005 the House of Lords set a very high threshold for those with HIV/AIDS in applying for leave to remain under Article 3 of the European Convention on Human Rights (ECHR). The decision authorized HIV-positive people living in the UK, where they are receiving antiretroviral therapy, to be deported to their home countries. A majority of the people who could be deported are from African countries that have high HIV prevalence and limited access to antiretroviral drugs.

5.2 Removal from the UK will be the equivalent of turning off a life-support machine as HIV Treatment is not readily available or affordable. The withdrawal of treatment increases the body's vulnerability to opportunistic infection and will result in drastically shortened life expectancy.

5.3 It seems incongruous for the Government to strive to "make poverty history" in Africa through granting aid and cancelling debt and yet, it is prepared to return soon to be terminally ill Africans to their home countries where scant or no resources for their care exists. HIV-positive people should be allowed to stay in the United Kingdom, at least until they might be able to return home when access to antiretroviral treatments becomes more widespread in Africa.

6. Recommendation

6.1 A Humanitarian Protection Exercise should be developed to allow certain categories of people currently on HIV treatment to remain in the UK.

October 2006

Joint memorandum submitted by HelpAge International and Help the Aged

1. Introduction

1.1 HelpAge International (HAI) and Help The Aged (HtA) welcome opportunity to provide evidence to the International Development Committee (IDC) on HIV and AIDS: marginalised groups and emerging epidemics.

1.2 The combined experience of our organisations in international development goes back over 40 years. HtA was founded in 1961 specifically to meet the needs of older people displaced by disasters and war in central Europe and Africa. Today, the HelpAge International network works with and for disadvantaged older people worldwide to achieve a lasting improvement in the quality of their lives. HelpAge International has been gathering evidence on the impact of AIDS on older people through programmes and research. Together we continue to ensure older people are not forgotten in development and aid programmes.

1.3 In offering evidence to the IDC we have chosen to focus our response on the issue of the provision of treatment, care and support to older people in developing countries.

1.4 We would welcome the opportunity to provide further information to the Committee if this would be of interest.

2. HIV and AIDS: Marginalised Groups and Emerging Epidemics

2.1 Many women and men over the age of 50 are sexually active and some inject drugs. They are therefore at risk of contracting HIV in the same way as those under 50 through sex and non-sterile equipment (whether through lack of universal precautions or for injecting drugs). However, their needs in terms of prevention programmes, treatment, and care and support may be different. The estimated 2.8 million people over 50 living with HIV require care and treatment services tailored to their specific needs, as current mainstream HIV services are failing to reach the marginalised majority.

2.2 The world is ageing fast with overall global average life expectancy increasing. Currently one in 12 people in developing countries are over 60 and this will increase to one in five by 2050. In countries where AIDS has caused average life expectancy to decline, this averaged statistic masks the realities and existence of millions of older people. Additionally, effective treatments are prolonging the lives of those who were infected at younger ages so that the share of HIV positive persons who are 50 and older is increasing substantially.

2.3 There is a lack of data and evidence on people over 50 affected by HIV and AIDS. Until recently, prevalence data was collected internationally only for people aged 15–49, ie those considered to be of reproductive age. But susceptibility to HIV infection continues beyond age 50. This exclusion of people over 50 from prevalence data has led policy makers and programme implementers to assume that women and men over 50 are not sexually active and/or not at risk of infection through sex or other modes of transmission. The subsequent lack of data and evidence on people over 50 has resulted in little emphasis by national AIDS councils, governments, donors and civil society in influencing national policies and practice to be responsive to people over 50 who are susceptible to infection or who are living with HIV.

2.4 The lack of information and prevention programmes targeted to older people about HIV transmission has led older women and men to also assume that they are not susceptible to infection. In parts of Latin America many older women and men believe the sole function of condoms is contraceptive rather than for disease prevention and control, so as they age older people who do not feel at risk of pregnancy are much less likely to use condoms. Free condom distribution programmes are often not accessible to older people, either because stigma prevents clinicians from offering condoms and older people from asking for them, or because the targeting of such initiatives at younger people can have the unintended consequence of causing older people to think they are not entitled to free protection.

2.5 Beyond prevention, older people face numerous barriers to accessing testing and treatment services. Large geographical distances between services can be insurmountable to many older people who have reduced incomes on retirement or reduced mobility as they age. For example, the State HIV and AIDS programme of Amazonas, Brasil, is acutely aware that its municipality (the size of England and the largest in the world) is a vast territory which limits the ability to provide full coverage of services. A person may travel three or four days to reach the state capital of Manaus to pick up their medications and return to their village only to have to return in 15 days to collect more Anti Retrovirals (ARVs). For many older people this kind of journey is simply unaffordable or too time-consuming to make. In sub-Saharan Africa where, in severely affected areas, up to 60% of orphaned or vulnerable children are being cared for by grandparents,

these primary carers cannot spend extended lengths of time away from their home, nor can they afford to spend scarce financial resources on transport to reach testing and treatment services. Many older women are particularly concerned about the risk of breached confidentiality in regard to Voluntary Ccounselling and Testing (VCT) which has deterred them from seeking testing.

Assuming that older people reach services, there remains a number of reasons why medical practitioners may be reluctant to test older people for HIV infection. Experience from the USA shows that persons aged 50 and over may not be promptly tested for HIV following the onset of HIV-related illnesses, because clinicians are less likely to consider HIV infection, reluctant to ask older patients about their sexuality, and more like to mistake symptoms for other age-related conditions. Many opportunistic infections that develop in a person with HIV that are often used by medical staff to determine if the patient may be HIV positive, such as thrush, are often common in older people. This age discrimination is exacerbated by the fact that HIV-related illnesses mimic other diseases associated with ageing, such as Alzheimer's. In addition, people over 50 may respond differently to drug therapies than younger people. Rather than invest in research to tailor therapies, older people are often excluded from clinical drug trials.

2.6 Where ARVs have been made available, it is important to note that they have worked better to lower the viral loads and reconstruct the immune system in younger populations than they have in older populations. For this reason when ARVs are scarce, and therefore rationed, access to them may be prioritised for younger people. Long term ARV use has shown a higher probability in various studies to kidney failure, heart disease, and liver damage in people over 50 living with HIV than in older people who are not HIV positive in the global North. There has been only limited analysis or research into long-term effects of ARV therapies in older populations in resource-poor societies.

2.7 Many governments now recognise that the world is ageing. Alongside this there have been some recent improvements in the recognition of older people's susceptibility to HIV infection and the increasing number of older people living with HIV. Most notably there has been a change in data collection policy by UNAIDS. In the 2006 Global AIDS Report, UNAIDS states that it no longer excludes people aged 50 and over in their nominal prevalence statistics. However, prevalence rates will continue to be provided using only age 15–49 age range for comparison across countries. According to UNAIDS the number of people who are living with HIV and who are over 50 is estimated at 2.8 million. In addition to nascent improvements in data collection there has been an increase in publicity in major media, particularly in the USA. However, much of its focus has been on the USA context rather than internationally. Older people and HIV infection issues in many developing countries remain under-recognised.

2.8 Thanks to demographic ageing, older people's issues are necessarily gaining momentum globally and it is vital that both the ageing and HIV agendas are brought together to respond more appropriately to older people who are susceptible to HIV infection or are living with HIV. A more inclusive approach to HIV and older people is required.

2.9 Drawing the International Development Select Committee members' attention to the evidence presented above HelpAge International and Help the Aged make the following recommendations that the International Development Committee:

— Strongly recommends that UK Department for International Development ensure that the concerns and rights of people over 50 are included and addressed in their own policies and practices and in those of the partners that they fund.

— Strongly recommends that the UK Department for International Development more consistently promotes and works in partnership with governments, researchers and the development community to ensure that HIV prevalence data on people over 50 is collected and disaggregated at national and international level by age and gender to enable policy makers and programme developers to design interventions that focus on improving responses for older people.

— Strongly recommends that the UK Department for International Development supports and advocates for research into older people and treatment issues, and for introducing appropriate and relevant training for medical staff to help them raise sexual and HIV issues with their older patients.

— Strongly recommends that the UK Department for International Development encourages national programmes, civil society and international donors alike to promote an inclusive approach towards older people in national HIV and AIDS programmes.

October 2006

Memorandum submitted by the International Planned Parenthood Federation (IPPF)

Summary of Recommendations

1. IPPF recommends that a focus is placed on increasing access to integrated SRH and HIV services for marginalised populations and recognising that treating poor SRH is integral to HIV prevention, treatment, care and support.

2. IPPF recommends that policy and programme efforts, within a human rights framework, should include a focus on eradicating stigma and discrimination to prevent the marginalisation of people within society. This should include specific efforts to remove laws that criminalise men who have sex with men and sex workers, as well as supporting harm reduction programmes for injecting drug users.

3. IPPF recommends the limits to categorising individuals as part of a specific group must be recognised in order to ensure services and messages reflect the real need. The language used to communicate issues around HIV and the link to marginalised populations must be used sensitively to prevent stigmatisation of these populations and to ensure wider populations also recognise their vulnerability to HIV.

4. IPPF recommends that efforts to alleviate the HIV epidemic must take into account the diversity of those infected and affected and have targeted programmes to address specific needs.

5. IPPF recommends that the principle of involving people should be extended to include all those excluded from existing decision making models and processes.

6. IPPF recommends that legislation and policies that restrict access to services for marginalised populations, and the collection of information on their experiences, should be reformed.

7. IPPF recommends that the existing SRH infrastructure is used to provide HIV prevention, treatment, care and support services.

8. IPPF recommends that the donor governments should provide financial and policy support to ensure the full provision of male and female condoms.

9. IPPF recommends the repeal of restrictive policies, at both domestic and international level, that impede harm reduction services.

10. IPPF recommends that the UK government should advocate for increased political commitment to support the needs of marginalised populations.

Background on the International Planned Parenthood Federation

1.1 The International Planned Parenthood Federation (IPPF) is a global network of 151 Member Associations working in 180 countries and is the world's foremost voluntary, non-governmental provider and advocate of sexual and reproductive health and rights.

1.2 IPPF aims to improve the quality of life of individuals by campaigning for sexual and reproductive health (SRH) and rights through advocacy and services, especially for poor and vulnerable people. We defend the right of all young people to enjoy their sexual lives free from ill-health, unwanted pregnancy, violence and discrimination. We support a woman's right to choose to terminate her pregnancy legally and safely. We strive to eliminate sexually transmitted infections and reduce the spread and impact of HIV/AIDS.

1.3 IPPF's strategy on HIV/AIDS aims to reduce the global incidence of HIV/AIDS and to protect the rights of those infected and affected. The four specific objectives towards delivering this strategy are 1) to reduce social, religious, cultural, economic, legal and political barriers that make people vulnerable to HIV/AIDS, 2) to increase access to interventions for prevention of HIV/AIDS/STIs through integrated, gender-sensitive and rights-based SRH programmes, 3) to increase access to care, support and treatment for people infected and support for those affected by HIV/AIDS, and 4) to strengthen the programmatic and policy linkages between SRH and HIV/AIDS.

We therefore submit this Memorandum to highlight issues and recommendations gained through our experience.

IPPF's Response to the Call for Evidence

— Evidence on the provision of HIV prevention, treatment, care and support to populations marginalized in society, including but not restricted to, commercial sex workers, intravenous drug users and men who have sex with men.

— Evidence on the extent to which HIV and AIDS policy and programming is effectively addressing emerging epidemics, including those in Eastern Europe and Asia.

1. *Poor Sexual and Reproductive Health (SRH) amongst marginalised populations increases vulnerability to HIV*

1.1 High incidence of Sexually Transmitted Infections (STIs) can occur in marginalised populations, thus increasing vulnerability to HIV.

1.2 Sexually Transmitted Infections increase the risk of HIV transmission.[27] Marginalised populations, such as sex workers, can experience high STI prevalence,[28] thus increasing their vulnerability to HIV. This situation is, in part, created by low access to services, compounded by stigma and discrimination (see point 2) which increase vulnerability to STIs, leading to poor SRH and consequently increasing vulnerability to HIV.

Treating poor SRH is a key aspect of successful HIV prevention, treatment, care and support. The links between poor SRH and HIV are strong, with action in one area necessitating action in the other—these links must be recognised at all levels. Equally, the synergies between prevention and treatment can lead to a more efficient use of resources and greater levels of both prevention and treatment. For example, treatment of STIs acts to reduce vulnerability to HIV and therefore acts as a mode of HIV prevention. There is a continuum of care between prevention, treatment and care with HIV and SRH integral.

Ensuring especially marginalised populations (Men who have sex with men (MSM), Injecting drug users (IDUs) and Sex Workers) can access necessary prevention and treatment services for STIs and HIV requires a recognition of their sexual and reproductive health and rights (SRHR). All too frequently, these populations are simply seen as recipients of treatment, with little regard to their individual rights. A programme in Nagaland, Northern India, delivered by the Family Planning Association of India[29] is providing SRH and HIV services to injecting drug users and their sexual partners, to not only address wider SRH and HIV goals, but also to meet the individual SRHR of these people.

1.3 IPPF recommends that a focus is placed on increasing access to integrated SRH and HIV services for marginalised populations and recognising that treating poor SRH is integral to HIV prevention, treatment, care and support.

2. *Stigma and discrimination*

2.1 The stigma and discrimination associated with HIV and AIDS frequently overlap with the pre-existing stigma attached to some marginalised populations. This leaves marginalised populations more vulnerable to HIV by reducing their access to necessary services.

2.2 Populations can be marginalised because of what is perceived as involvement in "deviant behaviour" (for example, injecting drug use). This pre-existing stigma can then overlap with HIV and AIDS related stigma and discrimination.[30] For example, in many societies sex between men is heavily stigmatised and consequently prevents people from trying to access relevant HIV services.[31] These views by wider society act to reduce the availability and provision of appropriate health services (including sexual and reproductive health services) that cater to the specific needs of these marginalised populations.

Stigma and discrimination are human rights violations. The recognition that people seen as "belonging" to marginalized populations have equal human rights is often lacking in formal policy. Equally lacking in many respects, is the recognition of the sexuality of people living with HIV, who experience stigma and discrimination which inhibits them accessing necessary services. The centrality of human rights to any response is identified in many policy documents.[32] This recognition should be linked to a concrete plan of action, on how to overcome stigma and discrimination. A core component of this, should be efforts to address societal attitudes about HIV and AIDS, in order to create a supportive environment in which people are able to access HIV (and SRH) services.

2.3 IPPF recommends that policy and programme efforts, within a human rights framework, should include a focus on eradicating stigma and discrimination to prevent the marginalisation of people within society. This should include specific efforts to remove laws that criminalise men who have sex with men and sex workers, as well as supporting harm reduction programmes for injecting drug users.

[27] For example, see UNAIDS *Sexually Transmitted Infections,* http://www.unaids.org/en/Issues/Prevention_treatment/sexually_transmitted_infections.asp

[28] *HIV and Sexually Transmitted Infection Prevention Among Sex Workers in Eastern Europe and Central Asia,* (UNAIDS Best Practice Collection, 2006) available from www.unaids.org

[29] FPA India is a Member Association of IPPF. The programme is delivered using funds from the Japan Trust Fund for HIV/AIDS.

[30] *HIV and AIDS related stigma and discrimination: a conceptual framework and implications for action* (Parker, R and Aggleton, P, 2002) Thomas Coram Research Institute.

[31] UNAIDS Policy brief, *—HIV and sex between men,* http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf

[32] For example, *Sexual and Reproductive Health and HIV/AIDS: a framework for priority linkages* (UNFPA, UNAIDS, WHO, IPPF, 2005).

3. *Marginalised populations are not homogenous or discrete*

3.1 The labelling of individuals as belonging to a specific marginalised group ignores the diversity and overlapping nature of identity and behaviour, and consequently needs, in relation to SRH and HIV.

3.2 The institutional imperative to categorise in order to measure and apportion resources and effort, although necessary, can undermine recognition of the true complexity and diversity of a situation. This applies equally to the identification of marginalised populations in the context of the HIV epidemic. The categorising of men who have sex with men can prevent the recognition of the variety of self-identities—gay, bisexual, heterosexual—and corresponding SRH and HIV needs. Diversity also cuts across "categories"—for example, the overlaps between injecting drug use and sex work.[33] Marginalised groups are not discrete or homogenous, which has implications for how services and information are designed, in that they need to reflect this complexity.

Categorising of individuals has outcomes for stigma and discrimination—where "groups" become identified as "vectors for transmission" rather than as individuals, and holders of human rights. Equally, an emphasis on marginalised "groups" can create a sense that if people don't identify with these groups then they are not vulnerable to HIV.

3.3 IPPF recommends the limits to categorising individuals as part of a specific group must be recognised in order to ensure services and messages reflect the real need. The language used to communicate issues around HIV and the link to marginalised populations must be used sensitively to prevent stigmatisation of these populations and to ensure wider populations also recognise their vulnerability to HIV.

4. *Targeted programmes*

4.1 Programmes and policies aimed at a general audience will not always address the needs of a specific marginalised population. As a result, in many emerging epidemics, HIV is concentrated in certain key vulnerable populations yet the resources are not targeted to match this need.

4.2 In many settings HIV is concentrated within specific populations (for example, sex workers, injecting drug users, men who have sex with men) and is not generalised across the population. Despite this, resources to combat the HIV epidemic are frequently used in programmes aimed at the general population. For example, many prevention activities have focussed on broad messages that do not account for the specific needs of certain marginalized and vulnerable populations. Inappropriate prevention programmes can mean those who most require services do not receive them. These could, in different regional and national settings, be MSM, IDUs and their partners, or sex workers and their partners. IPPF recognises the UK government is promoting the need to support vulnerable populations and rightfully raises the issues of affordability, stigma and discrimination—all barriers to effective action,[34] yet prevention and treatment programmes also need to be designed to cater for the needs of marginalized and vulnerable populations.

Targeting of programmes and policies to reach those marginalised in society must take account of the specific conditions and factors which affect people's lives. For example, PROFAMILIA in Colombia, an IPPF Member Association, has designed specific campaigns and messages to encourage men who have sex with men to access their integrated HIV and SRH services.[35] This programme highlights how resources can be used more effectively in targeted messages as well as in efforts to educate health providers.

4.3 IPPF recommends that efforts to alleviate the HIV epidemic must take into account the diversity of those infected and affected and have targeted programmes to address specific needs.

5. *Meaningful involvement of affected communities*

5.1 The involvement of affected communities in designing policies and programmes is key to appropriate and sensitively implemented services and information.

5.2 The principle of the Greater involvement of people living with HIV/AIDS (GIPA)[36] acts to encourage the involvement of PLHIV in all areas of the HIV response. This is intended to ensure not only that there are supportive environments for PLHIV, but that services are appropriate for a response. This same principle is now being applied in other contexts. A recent initiative seeks to include drug users in policies, programmes and services to respond to HIV.[37] The recent *Delhi Declaration* (which IPPF was involved in developing) discussed the sexual health of men who have sex with men and underlined the need to involve MSM in decision making, policy development and programme planning.[38]

[33] For example, see *HIV and Sexually Transmitted Infection Prevention Among Sex Workers in Eastern Europe and Central Asia*, (UNAIDS Best Practice Collection, 2006) available from www.unaids.org

[34] UK Government, *Taking Action, The UK's strategy for tackling HIV and AIDS in the developing world*, p 48.

[35] *Models of Care project, linking HIV/AIDS treatment, care and support in sexual and reproductive health settings: examples in action* (IPPF, 2005).

[36] See http://www.unaids.org/en/GetStarted/LivingWithHIV.asp

[37] *Nothing about us without us, Greater, meaningful involvement of people who use illegal drugs: a public health, ethical and human rights imperative* (Canadian HIV/AIDS legal network: 2005).

[38] The Delhi Declaration of Collaboration, 26 September, 2006, statement from *Risks and Responsibilities, Male Sexual Health and HIV in Asia and Pacific*, International Consultation.

5.3 IPPF recommends that the principle of involving people should be extended to include all those excluded from existing decision making models and processes.

6. *Criminalisation of behaviour*

6.1 Legislation and policies that make certain behaviours illegal: sex work, men having sex with men, injecting drug use, impede access to HIV and SRH services.

6.2 Policies and legislation that criminalise certain behaviours inhibit access to services. For example, criminalization of behaviours like injecting drug use complicates harm-reduction efforts and drives illegal drug use underground by making it harder for individuals to access services, eg needle exchange.[39] This criminalisation also acts to further the stigma and discrimination attached to these marginalised populations. A second issue is that criminalisation prevents the collection of information on the specific HIV prevalences and experiences of marginalised populations. This inhibits the development of effective policy and the efficient targeting of resources.

6.3 IPPF recommends that legislation and policies that restrict access to services for marginalised populations, and the collection of information on their experiences, should be reformed.

7. *Existing SRH infrastructure and services*

7.1 In many emerging epidemics there is a lack of infrastructure able to provide HIV prevention, treatment, care and support services.

7.2 Sexual and Reproductive Health clinics and other services (eg mobile clinics, outreach services, community based distribution) offer an existing infrastructure that can integrate HIV services in order to provide services in emerging epidemics. This provides synergies by: reducing resource use (eg costly physical infrastructure—new clinics etc), providing service-delivery points not directly associated with HIV and so mitigating the effects of stigma and discrimination surrounding HIV, as well as acting on the overlaps between SRH and HIV by providing common entry points for prevention, treatment and care. Linking these services provides opportunities to provide services for marginalised populations, for example in Kenya, the SRH infrastructure provided by Family Health Options Kenya (an IPPF Member Association) is being used to provide antiretrovial treatment.[40] Utilising this infrastructure, increases overall access to services. When combined with appropriate messaging and targeting of resources this can also increase access for marginalised populations (see point 4).

7.3 IPPF recommends that the existing SRH infrastructure is used to provide HIV prevention, treatment, care and support services.

8. *Condom availability*

8.1 There is a global shortage of the male condom, despite its proven ability to prevent the transmission of HIV.

8.2 According to UNFPA figures for 2000, to meet the total global condom need would have cost £314.8 million US dollars, in that same year only $45.9 million US dollars were given by donors.[41] A report by Interact highlights that in 2004 donors provided the equivalent of just four condoms per man in the developing world.[42] This condom gap has implications for both HIV and SRH prevention.

8.3 IPPF recommends that the donor governments should provide financial and policy support to ensure the full provision of male and female condoms.

9. *Low coverage of Harm Reduction programmes*

9.1 Many emerging epidemics are driven by injecting drug use, despite this there is low coverage of harm reduction programmes.

9.2 Harm reduction programmes aim to reduce the health and social consequences of injecting drug use.[43] There is substantial evidence to support their efficacy as a means of HIV prevention.[44] As the recent Government paper on harm reduction acknowledges, access to AIDS treatment for IDUs is an essential part

[39] "Illicit drug policies and their impact on the HIV epidemic in Europe," Godinho, J and Veen, J in *Europe, moving from death sentence to chronic disease management*, Matic, S, Lazarus, JV and Donoghoe, MC (eds) (WHO, 2006).

[40] *Models of Care project, linking HIV/AIDS treatment, care and support in sexual and reproductive health settings: examples in action* (IPPF, 2005).

[41] *Protection that only condoms provide*, from a 2002 report Global Estimates of Contraceptive Commodities and Condoms for STI/H\HIV Prevention 2000-2015, UNFPA, see www.unfpa,org http://www.unfpa.org/supplies/condoms.htm

[42] *Condom shortage, counting the cost in lives* (Interact Worldwide, 2006) available from www.interactworldwide.org

[43] *Harm reduction, tackling drug use and HIV in the developing world*, HM Government, December 2005.

[44] "Injecting drug use, harm reduction and HIV/AIDS," Martin C Donoghoe in HIV/AIDS in *Europe, moving from death sentence to chronic disease management*, Matic, S, Lazarus, JV and Donoghoe, MC (eds) (WHO, 2006) and *Harm reduction, tackling drug use and HIV in the developing world*, HM Government, December 2005.

of a harm reduction package, as well as a wider package of SRH services. Despite this support, there are barriers to scale up. These include restrictive policy environments, such as those in Russia that inhibit the scale-up of harm reduction programmes.[45]

9.3 IPPF recommends the repeal of restrictive policies, at both domestic and international level, that impede harm reduction services.

10. *Political commitment*

10.1 Political commitment is essential to ensuring the necessary policy environment in which action can be taken to prevent emerging epidemics from becoming large-scale.

10.2 The UK Government has acknowledged the importance of strengthening political leadership on HIV, particularly through its role in the G8 and EU and in supporting NEPAD and the African Union. However, political commitment is required beyond international policy discussions, it must also reach, and influence, grassroots policy and programmes. Political and community leaders should be supported in efforts to meet the needs of marginalised populations within their countries, as addressing these publicly can meet opposition. These nuances of political leadership must be recognised and supported.

10.3 IPPF recommends that the UK government should advocate for increased political commitment to support the needs of marginalised populations.

October 2006

Memorandum submitted by Naz Project London

1. This Memorandum arises from the ongoing lack of coherence in Government Departments relative to HIV policy and practice, specifically in relation to the goal of universal access to HIV/AIDS treatment relative to those who have failed in their asylum applications in the UK and to the deportation of those people living with HIV who have no right to reside in the UK.

2. Naz Project London is the longest established and largest Black and Minority Ethnic (BME) initiated and led sexual health agency in London. We are also the UK National Focal Point for "AIDS and Mobility Europe", an EU wide project on HIV and migrant/mobile populations. We currently work with the following BME and refugee communities in London: Eritrean, Ethiopian, Portuguese speaking (especially Brazilian, Angolan and Mozambican), Somali, South Asian, and Spanish speaking Latin American. We provide sexual health promotion and HIV/STI prevention, support and care for people living with HIV, and a dedicated sexual health and HIV policy and research capacity. Our service users are about equally split between those who are heterosexual and those who are men who have sex with men. Our sister organisation, Naz Foundation International, works mainly overseas in South Asia with men who have sex with men.

3. The Department for International Development is an active and admirable partner in achieving the UNAIDS goal of universal access to ARV treatments. However, this cannot be said about the coherence of HIV policy and practice when taking into account the positions of the Department of Health and the Home Office in the UK: there continues to be a serious lack of coherence.

4. I would like to bring the following to the attention of the Committee.

5. It is now widely understood that failed BME asylum seekers in the UK who had previously begun ARV treatment are entitled to continue such treatment. However, this information is still not getting out to the relevant BME communities: there is still confusion on the ground about whether or not failed asylums seekers can access ARV treatment and under what conditions. In addition, there appears to be no provision for access to treatment for asylum seekers who were not on ARV treatment prior to failing their asylum application. A public health rationale aiming at disease control for such an exclusion is lacking.

6. Deportations of failed asylum seekers living with HIV are continuing. These deportations include countries where ARV treatment is not practically available, eg, in terms of amount of medication available countrywide, geographic accessibility across the country, and costs (both for the medication as well as for travel to access it). In many such countries, HIV stigma is high indicating that access to appropriate HIV care, support and (secondary) prevention is seriously lacking. We know of serious rejection—including grievous domestic violence and family rejection—among some of our BME communities right here in the UK towards members who live with HIV. The situation is more serious in some home country contexts like Colombia, India or Somalia. The Home Office does not have a reputable methodology or accurate evidence base relative to determining what ARV medications are actually available in overseas communities.

7. I would therefore like to recommend the following to the Committee:

8. That the Committee urge the Department of Health to commit itself to the UNAIDS goal of universal access and ensure that all failed asylum seekers who are living with HIV have access to ARV treatment while they remain in the UK.

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[45] *HIV/AIDS and drug misuse in Russia, harm reduction programmes and the Russian legal system* (Butler, 2005).

9. That the Committee request that the Home Office freely open to public and scientific scrutiny the methodology or mechanism it uses to provide information about which countries have accessible ARV treatments and can therefore serve as deportation locations.

10. That the Committee ensure that a listing is prepared of countries where local legislation and/or custom blocks universal access to prevention, treatment, care or support especially for women and young females, sex workers, intravenous drug users, and men who have sex with men.

11. That the Committee invite those pharmaceutical companies that produce ARV treatments—and so are able to quantify the availability of ARV medication in various countries—to produce, either separately or in partnership, a publicly available database of this information.

Bryan Teixeira, Chief Executive

October 2006

Memorandum submitted by Plan UK

Summary

This submission, by Plan UK, aims to demonstrate how children and young people are marginalised in terms of HIV prevention, treatment, care and support. There are currently over two million children living with HIV around the world,[46] yet fewer than 5% of these have access to treatment.

In addition to the two million children infected by HIV globally, the needs of young people affected by HIV—through vulnerability, losing parents and family members and other factors—also need to be addressed.

Plan welcomes the emphasis on young people in "Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world", but more action is needed if children are to be protected and cared for in a world with HIV.

As well as highlighting the main ways in which children are marginalised in terms of HIV prevention, treatment, care and support, this submission also makes recommendations as to how the UK government could begin to respond better to the needs of children.

Introduction

1. Plan is an international child centred development organisation, committed to promoting the rights of children world-wide. We currently operate in 46 developing countries. Plan UK welcomes the opportunity to feed into the Committee's inquiry on groups marginalised in the provision of HIV prevention, treatment, care and support.

2. There are currently more than two million children living with HIV around the world.[47] In 2005 alone, 640,000 children were newly infected and 510,000 children died of HIV. A child dies of an AIDS-related illness every minute.

3. Despite this, the needs of children with HIV have been largely left out of the research agenda and their needs are still being over-looked when strategies on HIV prevention and treatment are drafted and policies are developed.

4. Fewer than 5% of HIV-positive children have access to treatment. Although there has been some improvement in recent years in paediatric access to treatment, children progress faster than adults to AIDS and therefore it is essential that the needs of children are addressed urgently in the drive for universal access to treatment.

5. It is important to recognise that as well as addressing the needs of the many children infected by HIV, there is also an urgent need to support children who are affected by HIV in some way, for example those who have been orphaned or are vulnerable to infection. Fewer than 10% of the estimated 14 million children who have lost parents to AIDS receive any public support or care.

6. The vast majority (almost nine out of 10) of the children affected by HIV and AIDS live in Sub-Saharan Africa and an estimated 15.7 million children there will have lost at least one parent to AIDS by 2010.[48]

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[46] UNAIDS, *Report on the Global AIDS Epidemic*, 2006.
[47] *Ibid.*
[48] UNICEF, *Children Affected by AIDS: Africa's Orphaned and Vulnerable Generations*, 2006.

How are Children Marginalised?

7. Although an increasing number of children worldwide are infected with HIV, their care and treatment is still not being treated as an urgent priority. Children form a silent majority in the world and it is often difficult for them to make their voices—and needs—heard. Governments are failing to sufficiently prioritise children in national plans of action on HIV and AIDS.

8. In many countries, there is a continued violation of children's sexual and reproductive rights and an increasing need to reduce children and young people's growing vulnerability to HIV infection. Factors which increase children's vulnerability to HIV infection—such as poverty and gender inequality—need to be tackled effectively.

1. *Prevention*

9. Children are the primary constituency for HIV infection, because their entire life will be influenced by the way in which the epidemic is growing. The people who have the greatest interest in preventing the spread of HIV are children, because spreading HIV infection has an impact on the life of a society in 20 to 30 years time, and not today.

10. Children are unable to protect themselves from HIV infection. Although HIV infection at birth has been almost eliminated in industrialised countries, many children in the developing world continue to be infected. Around 35–40% of HIV positive mothers transmit HIV to their babies, although proven interventions to prevent HIV transmission from mothers to children can reduce this risk to less than 5%. However, only 8% of HIV positive women in developing countries currently receive anti-retroviral treatment for Preventing Mother-To-Child-Transmission (PMTCT).[49] Not enough is being done to prevent babies being infected with HIV at birth.

11. A recent report by Plan International highlighted how lack of awareness is rarely the main reason for children's vulnerability to HIV infection.[50] Poverty, tradition, disempowerment, gender inequality and other social factors severely limit young people's margins of choice to adopt behaviours that protect them from HIV infection. Young girls are particularly vulnerable as they tend to be less likely to be in control of when they have sex, with whom and how. Early marriages to older men, sexual coercion and sexual violence all seriously impact on the ability of girls and young women to protect themselves:

> "My friend [a 13 year-old girl] lived on her own with her 11 year-old brother after their parents had died. Her uncle was a drunkard. He went with a drunken friend of his to the children's house and the friend defiled the girl. She got pregnant, and he also made her HIV-positive—at only 13 years of age." Prossy, aged 16, Uganda.[51]

12. Victims of child trafficking, a serious problem in West Africa and South Asia, are frequently exposed to HIV infection, particularly as many end up being exploited sexually or sold into prostitution. These children therefore have no ability to protect themselves from HIV infection.

2. *Access to diagnosis*

13. Children are also marginalised in terms of having access to diagnosis of HIV in many parts of the world. Although HIV testing and counselling services are starting to become widely available, they are often not youth-friendly, and children and adolescents rarely have access to these services.

14. Although antibody testing is widespread, it cannot be used for children under 18 months. Antigen testing, which could be used for these children, is expensive and not widely available. There is an urgent need to develop appropriate and affordable tests for children, as many cases of HIV infection in young children are currently going undetected.

3. *Access to treatment*

15. One of the most crucial ways in which children are marginalised is through lack of access to treatment. Although evidence suggests that children respond well to treatment and that universal access to treatment is a basic right of every child, less than 6% of those on antiretroviral treatment (ART) are children,[52] whereas at least 15% of those on treatment should be children.[53]

16. Without treatment, one in three HIV positive babies will have died by the age of one. Even using simple medication, such as cotrimoxazole, which are widely available and cheap, can make a big improvement in a child's health.[54] However, the majority of children in developing countries are still not

[49] UNICEF, *Children—The missing face of AIDS*, 2005.
[50] Plan International, *Circle of Hope: Children's Rights in a World with AIDS*, July 2006.
[51] Plan International, *Circle of Hope: Children's rights in a world with AIDS*, July 2006.
[52] World Health Organization, *Scaling up in resource poor settings—what about the children?*, a presentation given at ODI, 24 July 2006.
[53] UNICEF, *Children—The missing face of AIDS*, 2005.
[54] *Ibid.*

receiving any form of treatment. Routine use of cotrimoxazole for all babies exposed to HIV (ie born to HIV mothers) is affordable, easy to implement and would greatly reduce the mortality of children living with HIV. Yet this is still not being done.

17. Another key issue which is often neglected in HIV treatment programmes is nutrition. In order for HIV programmes to be effective, it is important that they address the issue of malnutrition which is widespread in many communities with a high HIV prevalence.

18. The health systems in many countries are simply not able to cope with the number of adults and children affected by HIV. In particular, many countries face serious human resources constraints in the health sector which is impacting on the provision of medical care and treatment to children with HIV. There is a limited capacity for health systems in terms of child health interventions and specialised services.

19. A key problem preventing all children from receiving treatment is the lack of "child-friendly" formulations that have been developed by pharmaceutical companies. Although there has been some progress made on this recently with the development of new drugs, the medication required by children is more expensive than adult formulations. Other problems concerning the drugs include the lack of simple dosing guidelines and problems with the shipment and storage of medicines.

4. *Legal issues*

20. HIV positive children often face discrimination and can be victimised by their community. In some cases, children infected with HIV are thrown out of their houses and denied their legal rights.

21. This is also a problem faced by a number of children orphaned by AIDS, as in some cases they have their property seized and are left homeless.

22. The failure of states to register the births of all children mean that often vulnerable children are denied access to inheritance, education and health care as they do not have an official birth certificate.

How does Plan's Community-based Response Work with Marginalised Groups?

23. Plan works to reduce children's vulnerability to infection. Preventing HIV infection at birth is part of Plan's work to improve the safety of pregnancy, delivery and infant care. In Uganda and in Benin, Plan supports the Ministry of Health in delivering services to prevent HIV infection among infants during pregnancy and delivery.[55]

24. The core focus of Plan's work is child-centred community development. A crucial part of this work involves supporting and strengthening community-based mechanisms of support for children affected by HIV to help reduce children's vulnerability.

25. Child protection work, such as combating child trafficking and advocacy to end early marriages, are vital in order to prevent children and young people from becoming infected with HIV.

26. Plan works to promote the legal rights of children affected by HIV and AIDS, for example by promoting universal birth registration. This is vital in order that every child is recognised as a citizen of their country. Without a birth certificate, children may be denied their basic rights, such as access to health care and education. It also enables children to claim their rightful inheritance, which is vital for children whose parents are suffering from AIDS.

27. Plan provides family therapy to support children and parents affected by HIV. This emotional support is vital and is an area that is often neglected in resource poor settings. A key part of Plan's HIV work involves planning for succession, which allows parents to help plan for their child's future. The use of memory books, pioneered in Uganda, is a way to help both children and parents to prepare for life after the death of one or both parents.[56]

28. Plan is working with Ministries of Health in a number of countries to make health services more "child and youth-friendly". This is vital both for the prevention of HIV in young people and in terms of the provision of treatment.

29. Plan focuses on improving nutrition and food security, livelihood and emotional support to children affected by HIV. An important part of Plan's work involves community mobilisation to eliminate stigma and discrimination, which is often directed at HIV positive children.

[55] Plan International, *Circle of Hope: Children's rights in a world with AIDS*, July 2006.
[56] Plan International, *Circle of Hope: Children's rights in a world with AIDS*, July 2006.

What Should DFID be Doing to Address the Needs of Children Affected by HIV?

30. DFID should ensure and encourage children's participation in HIV and AIDS programmes. The UK response to the global HIV epidemic should be developed in consultation with children and young people. In particular, DFID should recognise the key role of adolescents in HIV prevention.

31. DFID should work with national governments and partners to develop comprehensive social protection packages of support for all children and their families, encouraging national governments to commit a specific proportion of their national budget for such support and should recognise and respect minimum standards and targets. DFID should ensure that any measures directed towards vulnerable families are financially sustainable and are consistent with government thinking on "best practice" in social protection.

32. DFID should provide support to communities with a high HIV prevalence to help protect vulnerable children from being infected. A particular emphasis should be placed on areas where children are not being protected due to severe poverty and a lack of family support.

33. DFID should provide long-term, predictable, and increasing as a proportion as capacities build, financing for supporting the development of health services in developing countries. In the case of fragile states, DFID should better coordinate with non-governmental agencies providing health services.

34. DFID should continue to provide political leadership to ensure that the world comes as close as possible to the goal of universal access to anti-retroviral treatment by 2010, and to support developing countries in providing access to appropriate and affordable medicines, especially formulations and diagnostics adapted to the specific needs of children. The setting of specific targets for children needs to be included.

35. DFID should support the scaling up of innovative, local initiatives which help to prepare children affected by AIDS for the future.

October 2006

Memorandum submitted by Results UK

TB/HIV Co-epidemic

TB is the leading killer of people with AIDS, responsible for up to one-third of AIDS deaths globally according to the World Health Organization (WHO). It is estimated that up to half of people living with HIV/AIDS will develop active TB in their lifetimes. Once a person with HIV is diagnosed with TB disease, he or she typically dies within weeks in the absence of TB treatment. And unlike HIV, TB is curable in the vast majority of cases—even in people with AIDS. Yet only slightly more than half of those co-infected have access to effective TB treatment.

In sub-Saharan Africa in particular, the TB epidemic is worsening primarily as a result of HIV/AIDS—and is the only region in the world where TB rates are rising (by some 5% annually). The situation is so severe that last August, African Health Ministers and WHO declared TB a continent-wide emergency. Despite the obvious, demonstrated links between TB and HIV and the rising co-epidemic in sub-Saharan Africa this is not adequately reflected in policy or practice, for example, no reference to TB/HIV co-infection was made in DFID's publication, *Taking Action.*

In countries such as India, which now carries the highest burden of HIV/AIDS *and* TB it is critical that significant investment in fighting the co-epidemic is made now. This is even more necessary if the potential co-epidemic of HIV and Multi-Drug Resistant (MDR-TB) is to be stymied.

Major gains can be made in reducing mortality due to HIV/AIDS by investing in expanded TB control. Curing a person of TB who is co-infected with HIV has been shown to typically extend life by several years. This is particularly critical in the "window" of the next several years as we are a long way from universal access to ARVs. To provide universal TB treatment would be cost-effective, as a full course of TB drugs to cure one patient can be purchased through the Global TB Drug Facility (GDF) for under £9.00.

In addition, existing TB services are probably the single most important entry point for HIV testing, counselling and treatment. [For example, in Kenya some 60% of TB patients are HIV-positive; in Western Kenya, it is close to 90%.] The US President's Emergency Plan for AIDS Relief (PEPFAR) estimates that an additional 100,000 HIV patients could be placed on antiretroviral therapy in Kenya alone, by offering HIV counselling and testing to patients diagnosed with TB.

Given the challenges and delays in rolling out ARVs—such as those demonstrated by WHO's 3x5 initiative—universal access to TB treatment would save lives and buy precious time in which to access ARVs. This time is needed: sub-Saharan Africa has 81% of the world's estimated 741,000 cases of TB among HIV-positive people—only 4% have access to ARVs.[57]

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[57] WHO Report 2006, *Global Tuberculosis Control: Surveillance, Planning, Financing*, Geneva, Switzerland (WHO/HTM/TB/2006.232).

Recommendations

In line with commitments to integrate HIV and TB services made in the Commission for Africa report and the TB emergency declared in Africa, DFID could do far more to respond to the HIV epidemic by mainstreaming the co-epidemic in its HIV/AIDS portfolio and supporting countries to address TB/HIV co-epidemics. DFID could achieve this by allocating country budget support resources specifically for expanding TB services and tackling the TB/HIV co-epidemic, particularly for sub-Saharan African countries, and through investing in advocacy and communication initiatives to encourage HIV patients to seek testing, counselling and treatment services for TB and *vice-versa*.[58]

DFID should strategically increase and monitor specific TB and TB/HIV bilateral expenditures. In conjunction with this, DFID can play a key role by encouraging multilateral funding sources such as the World Bank and the Global Fund to recognise the challenge of the co-epidemic and proactively encourage increased investments accordingly.

By providing significant long-term predictable funding to mechanisms such as the Global Fund to Fight AIDS, TB and Malaria and promoting the scaling-up of the WHO "two diseases, one patient" strategy real progress can be made in the fight against HIV/AIDS.

Evidence Submitted by RESULTS UK

RESULTS is an international citizens advocacy organisation working to end hunger and the worst aspects of poverty. Founded in 1980, RESULTS supports volunteer advocates across the UK and six other countries worldwide (USA, Canada, Japan, Australia, Germany and Mexico). As part of a nationwide network citizens are supported in engaging with the democratic process and raising awareness of development issues with community leaders, elected representatives and the media.

RESULTS UK is currently working on a tuberculosis (TB) advocacy project. "ACTION"—Advocacy to Control TB Internationally—brings together RESULTS partners in the UK, USA, Canada and Japan alongside national governments and civil society in three high TB burden countries: India, Indonesia and Kenya. The project aims to address and reverse the global TB epidemic through policy analysis, education and high-level advocacy. With a particular focus on Africa, Asia and Eastern Europe, the ACTION project also educates policy makers on the growing TB/HIV epidemic and the effectiveness of collaborative TB and HIV services in high burden countries.

October 2006

Memorandum submitted by SABMiller

Introduction

1. As a South African-originated company with a presence in 29 African countries and a substantial African workforce, SABMiller is closely involved in initiatives to assist the development of the African continent. We are a founding member of Business Action for Africa.

2. The company is a genuine international African business success. Our 29 African businesses contribute around 40% of annual group turnover and over 14,000 of our 50,000 employees work in our African businesses. In addition to lager and sorghum brewing operations in Botswana, Ghana, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe, we also operate a brewing facility in Angola on a contract basis with the Angolan government and have bottling plants in seven of these countries. We are currently the fifth biggest bottler within the global Coca Cola system.

3. SABMiller welcomes the opportunity to submit evidence to the committee in advance of its oral evidence session with Department for International Development Parliamentary Under Secretary of State Gareth Thomas MP. The committee's commitment to holding an evidence session with the department on an annual basis is an indication of the importance of tackling the HIV/AIDS crisis urgently. SABMiller's position as a private sector operator with major exposure in Africa gives us a unique perspective.

4. SABMiller operates in a number of countries where HIV/AIDS is a major problem, such as Zambia, Botswana, Lesotho, Swaziland and South Africa. In such countries HIV/AIDS not only represents a devastating humanitarian disaster; it is also a major business risk, impacting on our employees, our customers and the communities in which we operate.

5. In this environment, it is essential that business takes action alongside domestic African governments, donor governments and the NGO community to tackle HIV/AIDS through education, prevention and treatment. SABMiller is committed to doing this and put in place a major programme to tackle the problem.

6. The committee is particularly asking for evidence on two distinct issues:

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[58] *Our Common Interest: Report of the Commission for Africa* (March 2005), p 197.

— The provision of HIV/AIDS prevention, treatment, care and support to groups which are marginalised in society, such as commercial sex workers, intravenous drug users and men who have sex with men; and

— the extent to which HIV/AIDS policy and programming is effectively addressing emerging epidemics, including those in Eastern Europe and Asia.

General Observations

7. We note the committee's observation in paragraph 15 of its original report on HIV/AIDS: "*Expanding access to HIV treatment should not be seen as a simple, technical fix to the pandemic. We believe that a scaling-up of HIV prevention must form an integral part of all programmes to expand access to treatment.*"

8. SABMiller is in complete agreement with the sentiment expressed here. Our basic strategy is focused on curative and preventative measures which depend on us being able to encourage staff and their dependents to be tested, to commit to treatment if they are diagnosed HIV positive and to change behaviours and attitudes which contribute to the spread of the virus. This strategy is ineffective if our staff do not participate. Regular surveys and research undertaken amongst our employees show that negative attitudes around stigma and taboos of HIV/AIDS are amongst the biggest reasons for employees not participating in treatment and testing. Therefore, government energies to prevent HIV/AIDS need to primarily be based around education to address stigma.

9. As part of this, SABMiller has made a number of commitments as part of the company's proactive HIV/AIDS strategy. These are to:

— Manage existing infections through voluntary counselling and testing;

— Provide managed healthcare which includes anti-retroviral treatment where necessary for employees and their direct dependents;

— Prevent new infections through education programmes which include a behaviour change methodology;

— Reduce stigma and negative attitudes which may exist at the workplace;

— Ensure that legislative requirements are adhered to; and

— Ensure that franchise requirements in respect of HIV/AIDS are adhered to.

10. We have also included owner drivers outside of our workforce in our education programmes. A four hour interactive workshop on HIV/AIDS was rolled out to SAB and ABI's approximately 450 owner drivers during 2005–06. SABMiller recognises the importance of empowering their owner drivers with this training as they are:

— Managing people;

— Managing the HIV situation amongst their crew (in terms of discrimination, confidentiality, victimisation and stigma, as well as understanding the incapacity process);

— Providing an opportunity for the owner drivers to ask questions;

— Understanding the legal implications associated with HIV;

— Providing the owner drivers with an opportunity to look at their own behaviour and those closest to them.

11. The workshops were well attended in all regions, and the delegates all received a training kit containing a condom negotiation wheel, a tape with an HIV story, developed by SABMiller, so that they can listen whilst they are driving, a STI chart, various Soul City comics, the Metropolitan Life HIV information booklet, a condom demonstrator with numerous packets of condoms, as well as a training manual. The Owner drivers are encouraged to share the information and material contained in the training kits with their crew and to give copies of the tapes to the crew so that these can be taken home and shared with the family.

12. Each SABMiller operating unit is also allocated a category rating depending primarily on the prevalence of HIV/AIDS in the country, and is then required to implement minimum standards based on this rating:

— Category A—a prevalence level of 5% or higher: These operations will have a strategic risk analysis and will develop, communicate and implement a policy. They will carry out knowledge, attitudes and practices (KAP) surveys and prevalence monitoring. They will also develop a comprehensive education programme with the focus on attitudes and behavioural change. Employees and their direct dependents will have access to condoms, education and treatment for sexually transmitted infections (STIs) and access to voluntary counselling and testing (VCT). Category A operations will also ensure HIV competence for key stakeholders and set up counselling and support structures.

— Category B—prevalence level of between 1% and 5%: These operations will develop, communicate and implement a policy. The policy will commit to a basic education programme regarding safer sexual behaviour and will offer access to condoms, education and treatment for STIs.

— Category C—prevalence of less than 1%: These operations will have division specific policy.

13. We believe that this approach has worked well in our existing operations and can be instructive to both the donor government and NGO community. We remain committed to continuous improvement and are, therefore, in regular dialogue with both governments and NGOs. In July 2005, for example, we held an HIV/AIDS workshop in conjunction with the Chatham House Africa programme. The purpose of the workshop was to share our HIV/AIDS methodologies with NGOs so we can identify the elements that can be replicated and used outside the work environment. The workshop was attended by HIV/AIDS NGOs, including Care International, as well as by representatives from the Mozambiquean and Ugandan High Commissions. Feedback and insights from this workshop have contributed to the development of our HIV/AIDS programmes, particularly with regard to dealing with this issue outside the workplace. Strategically this is vital if we are to continue extending our HIV/AIDS programmes into our supply chain and local communities.

Provision to Marginalised Groups

14. The committee has specifically mentioned a number of marginalised groups, including commercial sex workers, intravenous drug users and men who have sex with men. There are, of course, a number of other economically and socially marginalised groups such as children, particularly HIV/AIDS groups and other vulnerable individuals.

15. The key barrier to universal access to HIV/AIDS treatment is stigma, and this is particularly strong amongst marginalised and vulnerable groups. User fees also impact on access of course, and SABMiller has, therefore, been committed to providing free treatment to employees and their dependents.

16. SABMiller's strategy, taken forward through the company's "Confronting Prejudice and Stigma Campaign" has focused on reducing stigma, aiming to create an environment where employees feel safe to disclose their HIV/AIDS status.

17. We are also acutely aware of the possible links between alcohol abuse and unsafe sexual behaviour. There is no evidence that links increased prevalence of HIV/AIDS with people who drink. There is some evidence to suggest that people who drink irresponsibly participate in unprotected sex and SABMiller has programmes to tackle that by encouraging responsible drinking.

18. We also undertake education programmes for taverners. SAB Ltd Newlands Brewery, for example, embarked on a pilot project to train taverners as peer educators. This was rolled out in 2005 with a partner organisation, Planned Parenthood Association and is part of the Sensible Drinking programme.

19. 190 taverners attended a 10 day course and 20 attended a two day course. Taverners were provided with a resource kit containing training manuals, condom demonstrators and condoms, and educational material for distribution.

20. In addition support structures have been put in place and taverners are required to hold one workshop per month and track their activities. This workshop is in addition to the ongoing one-on-one and informal education which takes place. This is reported back to the partner organisation so that problems and barriers can be addressed. The feedback has been very positive from the taverners.

Emerging Epidemics

21. Aside from our operations in Africa, SABMiller also operates across Europe in countries including the Czech Republic, Hungary, Poland, Romania, Russia and Slovakia. We also have major interests in China and India and have recently agreed to enter Vietnam.

22. HIV/AIDS pandemics and their related consequences in some countries require us to manage HIV/AIDS as an operational and reputational priority, as indicated above. Africa, where the cost and impact of HIV/AIDS has been most significant, is our top priority, but the progression of the epidemic in India, China and Russia is also of concern.

23. As we have outlined elsewhere in this submission, each operation is categorised depending on the prevalence of HIV/AIDS within the countries and is required to implement minimum standards. We have implemented a policy and basic programme in Honduras where the prevalence is over 1%. This includes access to condoms as well as education and awareness programmes. We are monitoring emerging HIV/AIDS epidemics and will respond appropriately.

24. During 2006, we have also been consulting with potentially at risk operations in other regions to understand how our experiences in Africa may benefit them before the business impact of the disease becomes more evident.

Conclusion

25. Our key conclusions are as follows:

— HIV/AIDS core risk to business in terms of its impact on employees, customers and the wider community. Companies such as SABMiller are committed to working to tackle the disease to the greatest extent possible. Our aim is to influence our HIV and AIDS footprint through our spheres of influence. This includes employees, families, the supply chain and the community.

— SABMiller's basic strategy is focused on curative and preventative measures which depend on us being able to encourage staff and their dependents to be tested, to commit to treatment if they are diagnosed HIV positive and to change behaviours and attitudes which contribute to the spread of the virus.

— Our evidence-based approach is based on wide access to anti-retrovirals amongst employees and their dependents, reinforced by a comprehensive education and awareness programme. We are proud that participation in our programmes is widespread across Africa; for example, 80% of the workforce participating in Zambia.

— Education programmes across the board must tackle the stigma and prejudices associated with HIV/AIDS if they are to be effective. This is just as relevant for marginalised sections of society as it is for other employees. Inclusion should lie at the heart of policy.

— Africa, where the cost and impact of HIV/AIDS has been most significant, is our top priority currently, but the progression of the epidemic in Honduras, India, China and Russia is also of concern. Each operation is categorised depending on the prevalence of HIV/AIDS within the countries and is required to implement minimum standards. This ensures that we respond to emerging epidemics appropriately.

— During 2006, we have also been consulting with potentially at risk operations in other regions to understand how our experiences in Africa may benefit them before the business impact of the disease becomes more evident.

October 2006

Memorandum submitted by World Vision

1. World Vision welcomes this opportunity to make a submission to the International Development Committee. Evidence is submitted in three sections: Asia, Eastern Europe and children's access to paediatric treatment.

2. Asia: Marginalised Populations and Emerging Epidemics.[59]

National HIV infection levels in Asia are low compared with some other continents, notably Africa. But, populations of many Asian nations are so large that even low national HIV prevalence means large number of people living with HIV. Latest estimates show 8.3 million (5.7–12.5 million) people living with HIV in 2005 of whom 2.0 million are women. In 2005 the number of newly infected people with HIV was 1.1 million (600,000–2.5 million) adults including children and the number of deaths due to AIDS was 520,000 (330,000–780,000) adults, including children.

Asia is not just vast but diverse, and HIV epidemics in the region share that diversity, with the nature, pace and severity of epidemics differing across the region. Overall, Asian countries can be divided into several categories, according to the epidemics they are experiencing. While some countries have been hit early (for example, Cambodia, Myanmar and Thailand), others (Indonesia, Nepal, Vietnam, and several provinces in China) are only now starting to experience rapidly expanding epidemics and need to mount swift, effective responses. In Myanmar and parts of India and China HIV has become well-entrenched in some sections of society, despite efforts to halt the virus spread. Other countries (for example Bangladesh, East Timor, Laos, Pakistan and the Philippines) are still seeing extremely low levels of HIV prevalence, even among people at high risk of exposure to HIV, and have golden opportunities to preempt serious outbreaks.

(b) *World Vision's experience of working with marginalised populations in Asia*

World Vision has been implementing HIV and AIDS programmes for more than a decade. In light of the enormity and severity of the pandemic, World Vision has developed an organisation-wide "Hope Initiative." The Initiative's strategic framework aim is to reduce the global impact of HIV and AIDS, through the enhancement and expansion of programmes and partnerships focusing on HIV and AIDS Prevention, Care and Advocacy. World Vision has pioneered three core programming models to address

[59] UNAIDS *Report on the Global AIDS Epidemic* (2006).

the needs of the children and others affected by HIV and AIDS and they are: Community Care Coalitions caring for children and chronically ill adults, Church Based/FBO mobilisation and Life-Skills training for children aged 5–18.

World Vision has health teams in 16 countries in Asia and HIV prevention programmes in almost all of them, as well as STI programmes. World Vision tested innovative demonstration models of HIV interventions targeting female sex workers and their clients in six countries—Nepal, Bangladesh, Mongolia, Thailand, Papua New Guinea and Vietnam. The STI programmes were integrated in reproductive health and HIV programmes. STI projects focused on developing comprehensive models to reach sex workers and their clients and IDU's through four components: knowledge and awareness, friendly reproductive health services, participatory processes and an enabling environment. In most programmes, training was provided to both public and private health care providers in STI management and counselling and stigma reduction.

In Nepal, World Vision partnered with local NGOs to run mobile STI clinics, whilst in Vietnam, World Vision pilot-tested STI screening for sex workers. In Papua New Guinea, World Vision has worked with the Ministry of Health and a local university to introduce periodic presumptive treatment for sex workers and their clients (three rounds over nine months) and this provided the evidence base for the development of national policies and protocols in STI management.

In Bangladesh, World Vision conducted operations research with sex workers, rickshaw pullers, transport workers and college students and also ran an HIV and AIDS project (COX's Bazar) providing STI services to sex workers, men, women and youth in the community, including migrant workers. A peer educators model was used to refer people to Hospital, for diagnosis and treatment of STI's.

In Thailand, the PHAMIT project (Network of Prevention of HIV and AIDS) works with migrant population in 27 provinces and provides STI services as one of the key objectives. This project has been run in collaboration with other partners, including UNFPA, for over 12 years with the migrant population along the provincial border of Thailand and Myanmar. The migrants are helped to access the HIV and AIDS information, knowledge and health services through service delivery points. These services are provided to all the migrants with specific focus on sex workers, fishermen, MSM, youth and housewives. Other components include capacity building for the community health workers and volunteers, as well as providing quality, gender-sensitive integrated and age-specific reproductive health services (inclusive of HIV and AIDS prevention, counselling and care).

In India, World Vision has worked with MSM's in the state of Kerala with funding from the government. And in PNG, World Vision has worked with several MSM's who have become a backbone for the prevention of HIV in the Havana Bada project, funded by the Government through AUSAID.

World Vision has worked very successfully with churches and other faith communities in India, Papua New Guinea and Philippines to decrease stigma and promote constructive behaviour change and the potential of this work is enormous. The key component of the strategy is to mobilise faith leaders, and volunteers by intensive three day training which includes elements that will equip them and assist in engaging them in issues of HIV and AIDS, especially stigma and discrimination.

(c) *Recommendations*

World Vision recommends the following:

- Stigma is still the number one problem on HIV and AIDS which needs to be addressed in Asia. Leaders in government, faith communities and civil society must be more proactive in tackling the issue of stigma and discrimination and raising the profile of HIV and AIDS, as an emergency issue.
- All agencies involved in the fight against HIV and AIDS must document and scale-up work based on the evidence from lessons learnt from successful models that have been piloted in the region.
- Government and donors must ensure that they make long-term funding commitments for HIV and AIDS. Sustainability will only be achieved when people who have AIDS are able to support themselves and are brought more fully into designing and implementing programmes.
- Governments, civil society and faith communities must work together to establish and implement policies that will ensure that there is 100% condom use amongst high-risk groups.
- IDU's is another area that has significant gaps. It is critical that governments, CSO's and leaders are mobilised to address this problem and tackle the inter linkages between drugs, sex workers, and transmission of HIV among them.
- Prioritising gender vulnerability, specifically among girls aged 10–24, is very critical to any prevention efforts in the region. It is also critical to include boys as part of solution rather than regarding them as a problem.

3. Eastern Europe and Central Asia: Marginalised Populations and Emerging Epidemics

(a) *Nature of the epidemic*[60]

Eastern Europe and Central Asia Region has the fastest growing rate of HIV in the world. Unfortunately, the epidemics in Eastern Europe and Central Asia continue to expand—around 1.5 million [1.0 million–2.3 million] people were living with HIV in the region at the end of 2005—a 20-fold increase in less than a decade. In 2005, some 220,000 [150,000–650,000] people were newly infected with HIV. AIDS claimed the lives of an estimated 53,000 [36,000–75,000] adults and children in Eastern Europe and Central Asia in 2005—almost twice as many as in 2003. An estimated 420,000 [270,000–680,000] adult women were living with HIV in Eastern Europe and Central Asia in 2005—a third more than in 2003. Antiretroviral coverage remains inadequate in the region with only 21,000 of the estimated 160,000 people in need of treatment receiving it in 2005. Injecting drug users account for more than 70% of HIV cases in the region but represent only 24% of people receiving antiretroviral therapy (WHO/UNAIDS, 2006). In Eastern Europe, harm reduction programmes in 2005 reached only 9% of injecting drug users. The majority of people living with HIV in this region are in two countries: **Ukraine**, where the annual number of new HIV diagnoses keeps rising, and the **Russian Federation**, which has the biggest AIDS epidemic in all of Europe. More recent epidemics are underway in **Kazakhstan**, **Tajikistan** and **Uzbekistan**, where the annual number of new HIV diagnoses has been rising steeply. With the variety of international HIV and AIDS research based evident scenarios and predictions about the direction of the epidemic in Eastern Europe, it is expected that for most countries in the region HIV and AIDS will continue to grow over the next decade.

(b) *Needs of marginalised groups*

The socio-political context of Eastern Europe and Central Asia contributes to the trends of the epidemic described above. The profound societal changes that have swept across the MEER have created conditions that make the region particularly vulnerable to the spread of HIV. In Eastern Europe and Central Asia, most countries have epidemics concentrated in Most At-Risk Populations (MARPs)[61] and the so-called special risk groups[62] that "bridge" the epidemic between MARPs and the general population. They together with PLWH comprise the marginalised groups. In most cases the risks faced by marginalised groups are compounded by virtue of the fact that they belong to more than one "risk group".

In Eastern Europe and Central Asia unsafe behaviours prevail amongst MARPs and special risk groups and are exacerbated by a number of factors, including: women's perception of family fidelity which allows men to have sexual contacts with Sex Workers (SW) combined with the fact that sex outside marriage is regarded as the "norm" especially in the post-Soviet block. In addition, there is high out-migration for seasonal work to countries with concentrated epidemics/high prevalence and lack of social integration for children in institutions. Finally, there are unfavourable policies for targeting MARPs and special risk groups for HIV prevention.

The marginalised groups need to be supported to advocate for their rights to quality prevention and continuum of care.

(c) *World Vision's experiences of relevant interventions with these marginalised groups*

In line with World Vision's integrated approach to development, and the well-being and improved quality of life of beneficiaries, World Vision in Eastern Europe and Central Asia has mainstreamed HIV and AIDS interventions with a comprehensive mix of actions to meet the realities of the local context.

Although a child focused organisation, World Vision's focus in the concentrated epidemic context is the environment of the vulnerable child, which mostly includes IDU parents/mother, who might also be sex workers etc.

In Tashkent city, the capital of Uzbekistan, World Vision works with IDUs (1,193), sex workers (1,120), MSM (123) and their dependents. In Armenia, WV is the principal-recipient of GFATM and is managing a large grant facilitating the 12 projects implemented, 80% of which are targeting for IDUs, SWs and MSM. Both, the Uzbekistan project and Armenia programme are also targeting PLWH, who at times are in both groups, providing more complication for quality service provision. In a number of countries, including Russia, World Vision targets children that are at significant risk (those categorised as special risk groups) and tries to influence their behaviours through sensitised and mobilised faith leaders.

[60] UNAIDS *Report on the Global AIDS Epidemic* (2006).

[61] These are populations within a country at the highest risk of transmitting HIV, constituting injecting drug users (IDUs), sex workers (SWs), and men who have sex with men (MSM). There is a lack of data on MSM, and hence disagreement over whether MSM are really one of the MARPs.

[62] Those having frequent sexual contact with MARPs, consisting of partners of IDUs, children/youth that are in institutions (orphanages, boarding schools, vocational schools, homeless shelters, etc), those trafficked or under the risk of being trafficked, migrants/seasonal workers (including truck drivers).

(d) *Recommendations*

World Vision recommends the following:

(i) Facilitating the documentation and replication of best practice. World Vision itself has some projects that are demonstrating some promising results but such projects are still pockets rather than being at scale. The MARP need to be provided with services in a much more accessible manner to reduce risk. Needle exchange, drug rehabilitation and condom promotion programmes adhering to recognised good practice need to be rolled out at scale.

(ii) Governments must work with civil society to find better ways to provide services to enable IDUs and other marginalised groups to access treatment.

(iii) There is also a need to integrate responses because there is a significant overlap of people engaged in sex work who are also injecting drugs.

(iv) Governments must be encouraged to be more open to talk about HIV and AIDS and make it a greater priority. While donor funding is important, national level leadership on the issue is a critical component.

(v) Children protection programmes must be undertaken to protect children from being exploited as sex workers and from becoming injecting drug users. These must also include the children whose parents are sex workers and/or injecting drug users.

4. Children as a Marginalised Group: Global Access to Paediatric Treatment[63]

Children living with HIV are a particularly marginalised group and yet are virtually invisible. Some 2.3 million children under the age of 15 are living with HIV worldwide—more than 95%—live in developing countries with no access to any form of care or treatment they desperately need. Some 2,000 children are infected with HIV every day, principally through parent to child transmission and in 2005 alone 570,000 children died of AIDS-related diseases. Yet these children are virtually invisible and, by virtue of their absence from decision-making forums, their needs are frequently overlooked.

Without treatment, most children with HIV will die before their fifth birthday. In Africa, where children have the least access to any treatment—both to prevent infection and to combat the disease—AIDS has already caused infant mortality to increase by more than 19% and contributes strongly to increases in under-five mortality.

The deaths of these children are **not** inevitable; HIV-positive children can and do respond to antiretroviral treatment. However, despite recent increases in the number of adults on antiretroviral therapy (ART), the number of children receiving treatment remains unacceptably small. Currently, 8% of HIV-positive children have access to the paediatric AIDS treatment they desperately need. They must be given their chance at life.

(a) *Prevention of Mother-to Child-Transmission (pMTCT)*

The failure to prevent mother-to-child-transmission (MTCT) drives the rapidly increasing number of HIV-positive children. Globally, 90% of all HIV-positive children are infected through MTCT. Without prevention of mother-to-child-transmission (pMTCT) services, about 35% of infants born to HIV-positive mothers will acquire the virus during pregnancy, labour, delivery or breastfeeding. Providing a mother with a full range of pMTCT services can reduce this risk of transmission to less than 2%. But less than 10% of HIV-positive pregnant women globally and 6% of pregnant women in sub-Saharan Africa are receiving pMTCT services.[64] This is a gross violation of the rights of both these women and their children.

(b) *Access to cotrimoxazole*

Cotrimoxazole is highly effective in preventing life-threatening opportunistic infections in HIV infected children. For example, a study in Zambia found up to a 43% drop in mortality when HIV infected children had access to cotrimoxazole alone.[65] Because HIV is more aggressive in children, they are highly prone to opportunistic infections, particularly during the first few months of life when HIV diagnosis in children is extremely difficult. Given these realities, cotrimoxazole is recommended for all children born to HIV infected mothers until the HIV status of the child is confirmed negative. As of June 2005, an estimated four million children need this life saving treatment, costing less than three cents of a dollar a day per child.[66] This is a small price for saving many lives.

[63] This evidence draws substantively on *Saving Lives: Children's Right to HIV and AIDS Treatment*, published by the Global Movement for Children, of which World Vision is a member.

[64] UNAIDS, *Report on Global AIDS Epidemic*, May 2006.

[65] UNAIDS (2005) *AIDS Epidemic Update: December 2005* Joint United Nations Programme on HIV/AIDS, Geneva.

[66] UNICEF (2005) *A Call to Action: Children, the Missing Face of AIDS.*

(c) *Diagnostics*

Treatment cannot start without clear diagnosis. The most commonly available and easy to use diagnostic test is inaccurate in children under 18 months of age.[67] Infant diagnosis requires a complicated test measuring the presence of the HIV virus.[68] Unfortunately, these tests require technical expertise as well as costly equipment, placing them out of reach of poor countries.[69] The lack of widespread diagnosis of children with HIV/AIDS hinders accurate forecasting of the demand for pediatric drugs and personnel.

According to Médecins Sans Frontières, up until 2005, multinational companies that produce diagnostic tests have shown little interest in developing accurate, simple, fast and affordable tests for diagnosing HIV infection in children[70] or in supporting national owned initiatives. Without treatment, up to 60% of HIV infected children will die before their second birthday[71]—delayed diagnosis and treatment is simply not an option.

(d) *Children's access to treatment*

At the end of 2005, 700,000 children needed antiretroviral therapy. Where treatment is available, more than 80% of children live to see their sixth birthday. Some children are surviving until their 20s.[72] Denying children the right to treatment denies them the right to survival, growth and development.

The number of children on treatment has doubled over the last year from approximately 20,000 to 52,500.[73] However, given that roughly 1.3 million of the six million adults in need of treatment are on currently receiving antiretroviral therapy, approximately 140,000 of the 700,000 children in need of treatment should be on ART.

Children's right to treatment is specifically outlined in the 2003 General Comment 3 on HIV/AIDS and the rights of the child issued by of the Committee on the Rights of the Child.[74] Ultimately, it is the responsibility of signatory governments to uphold a child's right to prevention, care and treatment. Children can and do respond to treatment.

The limitations of current formulations are substantial:

- Most paediatric formulations are available either in liquid form—raising issues of volume measurement, palatability and refrigeration—or in a powder form—which must be mixed with clean water;
- Some tablet and capsule formulations are available only for adult consumption, forcing practitioners to chop or crush them;
- Even with access to first line-regimes, expensive second-line drugs must be available to address issues of resistance and intolerability.

The lack of research and development means that treatment of children is often imprecise. Health care workers and caregivers are forced to make do with what is available, often crushing adult tablets and estimating doses. This is complex for the caregiver and imprecise for the child, reducing lifesaving treatment to a guessing game. Drug treatment is only one part of a comprehensive package of care and support that children require. But as long as drug treatment for HIV-positive children remains inadequate, their overall treatment needs cannot be met.

Recommendations on: World Vision calls on the UK Government to continue providing leadership on achieving universal treatment for all by 2010 and as part of this uphold children's right to HIV and AIDS treatment. We specifically call for the UK Government to challenge national governments, UN agencies and donors to do the following:

1. Prevention of Mother to Child Treatment: To achieve the Abuja Call made by African Heads of State for Accelerated Action Towards Universal access to HIV and AIDS that at least 80% of HIV-positive pregnant women have access to prevention of mother-to-child-transmission (pMTCT) services. Governments, donors and NGOs must immediately:

- Increase the resources needed to scale-up the number and size of pMTCT programmes to provide HIV-positive women with appropriate interventions to prevent mother-to-child transmission that includes infant testing, nutritional supplementation, and long-term ART.

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[67] The Elisa test is an HIV antibody test that measures the body's immune system response following infection. It is not accurate in children under 18 months because maternal antibodies can still be in the child's body until this time.

[68] HIV DNA Polymerase Chain Reaction tests (PCR)—for more information see www.aidsmap.com

[69] Medécins Sans Frontières (2005) *Paediatric HIV/AIDS* Fact sheet, MSF Campaign for access to essential medicines. June 2005.

[70] Medécins Sans Frontières (2005) *Paediatric HIV/AIDS* Fact sheet, MSF Campaign for access to essential medicines. June 2005.

[71] UNAIDS *Report on the global AIDS epidemic* (2004) Joint United Nations Programme on HIV/AIDS, Geneva.

[72] Global AIDS Alliance (2005) *Treat the Children: Accelerating Action for Universal Antiretroviral Treatment for Children in Resource-Limited Countries by 2010*, Advocacy Brief. July 29, 2005.

[73] Global AIDS Alliance (2005) *Children Left Out: Global Community Failing to Scale Up the Prevention and Treatment of Pediatric HIV/AIDS*. Advocacy Brief, August 2006.

[74] Committee on the Rights of the Child, CRC/GC2003/1.

— Develop and implement action plans to provide cotrimoxazole to all children known to be HIV-positive and to all those born to HIV-positive mothers until their HIV status is determined.

2. Diagnostics:

— Governments and donors must negotiate lower prices on diagnostic test kits and test equipment.

— Diagnostics manufacturers must accelerate research into point-of-care infant diagnostics.

3. Paediatric treatment

By 2010, in line with the Abuja Call, governments, UN agencies and donors must:

— Ensure that at least 80% of all children in need of treatment have access to HIV and AIDS treatment, including antiretroviral therapy;

— Include children explicitly in international treatment initiatives and national treatment targets and then track treatment distribution by collecting data by age and gender;

— Encourage developing countries to make use of TRIPS flexibilities, including providing technical assistance on the use of existing flexibilities, and, where feasible, helping develop domestic generic manufacturing capacity;

— Improve health care systems of poor countries to deliver drug treatment, member states must: prioritise the health care sector in national budgets; provide comprehensive treatment guidelines; and training packages on treating HIV positive children for health professionals;

— Make healthcare free and increase investment in health systems. Health systems should provide holistic care, including emotional support and access to home-based care that enables mothers to stay in their homes and care for their children. However, this should be undertaken without increasing the burden of care that women and girls carry, through providing appropriate support and compensation.

Industry must:

— Prioritise children's rights over market interests and urgently invest in the development and production of fixed-dose combination antiretroviral therapy for young children as well as grant voluntary licenses to allow generic production of ARVs and develop simple and affordable diagnostic tests for children and infants.

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